

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)  
30M REV. 1/68

12310		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12320					
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
MARY		E.		ABBOTT				09 Month 03 Day 68 Year		2:10 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		WHITE		09-19-12		55 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
WEST VIRGINIA		U.S.A.				ALLEGANY COUNTY,				Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND		SACRED HEART HOSPITAL		CLERK		DEPT. STORE					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
MARYLAND		ALLEGANY		LONACONING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		23 DOUGLAS AVENUE			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
David		E.		Park				Winifred		Guy	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
Yes, no, NO		219-03-8164		SACRED HEART HOSPITAL-900		SETON DR., CUMB., MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial Infarction</i> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Extensive Myocardial Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Unlabeled</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		8 hrs		unlabeled					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 9/2, 1968, to 9/3, 1968, that (I) (we) last saw the deceased alive on 9/3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
<i>J. A. Pagan</i>		9/4/68		J. A. PAGAN, M.D.		5 POTOMAC ST., RIDGELEY, W. VA. 26753					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		9/5/68		Laurel Hill Cemetery		Moscow A. Md.					
24. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
EICHORN FUNERAL HOME-8 E. MAIN ST.,		LONACONING, MD		DATE SEP 6 1968		<i>Charles Judge</i>					

Y.7A2

ТІЛ-ША

7. JOURNAL

27142

21-01-00

22

9.111214 T23

• • •

LIBRARY

CHARTERED

JAFI 3201. TAF 34 0757.43

27310

250T2, T430

000000

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

7. 12. 1952

21

-10-20

U.S. GOVERNMENT PRINTING OFFICE: 1967 O - 380-380

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1517  
30M REV. 1-68

12311												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												12321																																															
1. DECEASED-NAME (Type or print)												2a. DATE OF DEATH												2b. HOUR																																															
NICHOLAS M. ABEY												SEPTEMBER 8, 1968												6:15PM																																															
3. SEX MALE												4. RACE WHITE												5. DATE OF BIRTH 11-14-1888												6. AGE (In years last birthday) 79 YRS.												IF UNDER 1 YEAR MONTHS DAYS												IF UNDER 24 HRS. HOURS MIN.											
7a. BIRTHPLACE (State or foreign country) MARYLAND												7b. CITIZEN OF WHAT COUNTRY? USA												8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>												9. COUNTY OF DEATH ALLEGANY												Md.																							
10. CITY OR TOWN OF DEATH CUMBERLAND												11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL												12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Carmen Helper-Retired												12b. KIND OF BUSINESS OR INDUSTRY B & O R R																																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. VA.												13b. COUNTY RIDGELEY												13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												13e. STREET AND NUMBER 41 BRIDGE ST.																							
14. FATHER'S NAME JOHN H. ABEY												15. MOTHER'S MAIDEN NAME MARY MC KENZIE												16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) WW 1												16b. SOCIAL SECURITY NO. 232-20-6589												17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.												Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberc pneumonia</u> 492X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 5271 <u>chronic pulmonary hypertensive heart disease</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 Days																																																											
19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED												20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>												20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)												21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19												21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																															
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at home												21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)												21f. LOCATION Street or R.F.D. No. City or Town County State																																															
22a. I certify that (I) (this hospital) attended the deceased from 8-30, 1968, to 9-8, 1968, that (I) (we) last saw the deceased alive on 9-8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE V. Dross DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												22c. DATE SIGNED 9-9-68																																															
22d. PHYSICIAN'S NAME (Type) DR. V. DROSS												22e. ADDRESS 456 N. CENTRE ST., CUMBERLAND, MD.																																																											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial												23b. DATE 9/11/1968												23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park												23d. LOCATION (City or Town) (County) (State) Near Cumberland Alleg Md.																																			
24. FUNERAL DIRECTOR John J. Hafer, Jr.												24a. ADDRESS 230 Balto Ave Cumber Md												25a. REC'D BY REGISTRAR SEP 16 1968												25b. REGISTRAR'S SIGNATURE J. Charles Judge																																			

100-100000

RECEIVED OF 1000

NICHOLS M. AVEY SEPTEMBER 1950

11-10-1950

WIFE

WIFE

ALLGANT

WIFE

USA

MARYLAND

GENERAL HOSPITAL

CURET AND

RIDGELY

W. A.

MC. CHIEF

AVEY

JOHN

GENERAL HOSPITAL, CURET AND

USE B. DENTIST AT, CURET AND

DR. W. DENTIST

SEP 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

12312

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12322

1. DECEASED-NAME (Type or print)		First <b>DEWEY</b>	Middle <b>D.</b>	Last <b>BARNES</b>	2a. DATE OF DEATH Month <b>09</b> Day <b>02</b> Year <b>68</b>		2b. HOUR <b>2:20P</b> M		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>11-07-99</b>		6. AGE (In years lost day) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b>			Md.
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SACRED HEART HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired Paper Mill</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>BARTON</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RT. 1.</b>	
14. FATHER'S NAME First <b>Sherid</b> Middle <b>ELWOOD</b> Last <b>BARNES</b>		15. MOTHER'S MAIDEN NAME First <b>SARAH</b> Middle <b>DIEHL</b> Last <b>DIEHL</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>213-03-0803</b>		17. INFORMANT Address <b>HOSPITAL RECORD-SHH-CUMBERLAND, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1621 Bronchogenic Carcinoma.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1621</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Generalized Arterio-sclerosis.</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Clarence J. Vincent - M.D.</b>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <b>DR. VINCENT - BMG</b>		22e. ADDRESS <b>SETON DR., CUMBERLAND, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/5/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Potomac Valley Gardens</b>		23d. LOCATION (City or Town) (County) (State) <b>Keyser Mineral W. Va.</b>			
24. FUNERAL DIRECTOR <b>BOALS WESTERNPORT, MD.</b>		ADDRESS <b>Westernport, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 9 1968</b>		25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>			

BOULEVARD WESTERN, 100

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. File along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12313

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12323

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED		Month		Day		Year		2b. HOUR	
JOSEPH				BARRINGER						9-12				68		4:10 AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		Month		Day		Year	
Male	White	May 6, 1896		72 YRS		MONTHS		DAYS		9		12		1968		10 AM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH									
Virginia		USA		WIDOWED		DIVORCED		Allegany								Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY											
Cumberland		D.O.A. Memorial H.		Retired Fireman		Railroad											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER									
Md.		Allegany		Cumberland		YES		915 Virginia Ave.									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last			
Joseph				Barringer				Susan Rainer									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
no				Claude Barringer, Cumberland, Md.-Son													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF CORONARY OCCLUSION CORONARY SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN "															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO									
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State							
22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner																	
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		22b. DATE SIGNED									
EXAMINER'S NAME (Type)		Dr. Benedict Skitarelic, M.D.		ADDRESS (Street, city, town, or county)		Rt. 9, Cumberland											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)							
Burial		Sept. 15, 1968		Rose Hill Cemetery		Cumberland, Allegany, Md.											
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
James F. Scarpelli, Cumberland, Md.				DATE		SEP 17 1968											



1937

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1937

STATE OF



1937



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12314										12324									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH				2b. HOUR							
OTTO		CLIFTON		(C.)		BEAN		9 Month 12 Day 68 Year				11 A M							
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
MALE		WHITE		10/2/99				68 YRS.		MONTHS		DAYS							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.									
WEST VA.		UNITED STATES		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		ALLEGANY CO.,													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY													
CUMBERLAND		SACRED HEART HOSP.		CUSTODIAN - School		CUSTODIAN													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER											
MARYLAND		ALLEGANY		CUMBERLAND		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		320 BOND STREET											
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last					
EMORY		BEAN		MARY		(STARKEY)		STARKIE											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT				Address											
NO		217 10 6400		PATIENT'S HOSPITAL CHART															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) <i>Mesenteric thrombosis, Mesine</i>										6 hrs									
DUE TO, OR AS A CONSEQUENCE OF																			
(b) <i>ASHD &amp; Atrial Fibrillation</i>										unk.									
DUE TO, OR AS A CONSEQUENCE OF																			
(c) <i>Generalized arteriosclerosis</i>										unk.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																			
4200 <i>Pulmonary Embolism</i>																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?													
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		yes													
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. Month Day Year																	
(If either, notify medical examiner)		P.M. 19																	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION				City or Town				County							
While <input type="checkbox"/> Not while <input type="checkbox"/>				Street or R.F.D. No.															
at work <input type="checkbox"/> at work <input type="checkbox"/>																			
22a. I certify that (I) (this hospital) attended the deceased from <i>8/1/68</i> , 1968, to <i>9/12</i> , 1968, that (I) (we) lost saw the deceased alive on <i>9/12</i> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE		22c. DATE SIGNED		22d. ADDRESS															
<i>[Signature]</i>		9/16/68		1068 NATIONAL HIGHWAY, LA VALE, MD.															
22d. PHYSICIAN'S NAME (Type)		DR. J. A. PAGAN																	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)									
Burial		Sept. 15, 1968		St. Luke's Cemetery		Cumberland, Md.		Allegany											
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
James F. Scarpelli, Cumberland, Md.				SEP 18 1968		<i>[Signature]</i>													

DATE		10/10/50	
TIME		10:00 AM	
PLACE		NEW YORK	
REASON		MARRIAGE	
NAME		JOHN DOE	
ADDRESS		123 MAIN ST, NEW YORK, NY	
OCCUPATION		CLERK	
EDUCATION		HIGH SCHOOL	
MILITARY SERVICE		NONE	
RELIGION		CATHOLIC	
PARENTS		JOHN DOE, MARY DOE	
SIBLINGS		NONE	
MARRIAGE HISTORY		NONE	
CHILDREN		NONE	
SIGNATURE		JOHN DOE	
WITNESSES		JOHN DOE, MARY DOE	
OFFICIAL		JOHN DOE	

10/10/50  
 NEW YORK  
 MARRIAGE  
 JOHN DOE  
 123 MAIN ST, NEW YORK, NY  
 CLERK  
 HIGH SCHOOL  
 NONE  
 CATHOLIC  
 JOHN DOE, MARY DOE  
 NONE  
 NONE  
 JOHN DOE  
 JOHN DOE, MARY DOE  
 JOHN DOE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last <b>Benson Hill Bell</b>						2a. DATE OF DEATH Sept. 23, 68 Year			2b. HOUR 4:55 P.M.			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Oct. 1, 1879</b>			6. AGE (In years last birthday) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Georgia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b> Md.						
10. CITY OR TOWN OF DEATH <b>Cumberland,</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Memorial Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Ret. Tax Collector</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>County Gov't</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Penna.</b>		13b. COUNTY <b>Bedford,</b>		13c. CITY OR TOWN <b>Cumberland, Md.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Pine Ridge Road</b>				
14. FATHER'S NAME First Middle Last <b>Benson A. Bell</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Fannie -- Hargrove</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (p, or unknown) <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>254-50-7476</b>		17. INFORMANT Address <b>Mrs. Russell G. Eversole Rt. # 2 Box 692, Cumberland, Md.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>492X Congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Tobacco pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Re pneumothorax</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1</b> <b>8 days</b> <b>10 days</b>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>5271 Pulmonary embolism</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>9-13, 1968</b> , to <b>9-23, 1968</b> , that (I) (we) last saw the deceased alive on <b>9-23, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Vasilios P. Dross MD</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Sept. 24, 1968</b>				
22d. PHYSICIAN'S NAME (Type) <b>Vasilios P. Dross, M. D.</b>						22e. ADDRESS <b>456 N. Centre St. Cumberland, Md. 21502</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/27/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>West View Cemetery,</b>		23d. LOCATION (City or Town) (County) (State) <b>Atlanta, Fulton, Georgia</b>						
24. FUNERAL DIRECTOR <b>H. Wayne George Cumberland, Maryland</b>						25a. REC'D BY REGISTRAR DATE <b>SEP 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>				

# UNITED STATES OF AMERICA

IN SENATE, JANUARY 24, 1932.

REPORT OF THE

COMMISSIONERS OF THE

LAND OFFICE

RECEIVED

DECEMBER 1, 1931

UNITED STATES OF AMERICA

REPORT OF THE

COMMISSIONERS OF THE

LAND OFFICE

RECEIVED

DECEMBER 1, 1931

UNITED STATES OF AMERICA

REPORT OF THE

COMMISSIONERS OF THE

LAND OFFICE

RECEIVED

DECEMBER 1, 1931

UNITED STATES OF AMERICA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12316		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		12326	
Item #13c Film 05 10/18/68 km		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print) First Middle Last Douglas R. Bowie			2a. DATE OF DEATH Sept Month 12 Day 68 <sup>year</sup>		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH May 6, 1902		6. AGE (In years lost birthday) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Cumberland Md. U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.
10. CITY OR TOWN OF DEATH Cumberland Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 210 Forest Drive		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Gen. Co. Pres. Paper	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md		13b. COUNTY Allegany	13c. CITY OR TOWN Cumb. Md.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 210 Forest Drive
14. FATHER'S NAME First Middle Last Robert E. Lee Bowie		15. MOTHER'S MAIDEN NAME First Middle Last Charlotte Wilson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. —		17. INFORMANT Mrs. Douglas Bowie Cumb. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4-25-1968, to 9-12-1968, that (I) (we) last saw the deceased alive on 8-20-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Rm. J. Williams		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9-14-68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 1220 Centre St. Cumberland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/14/68		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.	
23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md		23e. REGISTRAR'S SIGNATURE Charles J. J...			
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 16 1968	

1951

STATE OF OHIO

1951





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12317		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12327			
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH		2b. HOUR P	
First		Middle		Last		Month Day Year		3:45 M	
ROSE		A.		BRAILER		9 - 21 - 68			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
FEMALE		WHITE		10-15-95		72 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		USA				ALLEGANY Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give address)		12a. USUAL OCCUPATION (Kind of work done during life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		SACRED HEART HOSPITAL		HOUSEWIFE					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD.		ALLEGANY		MT. SAVAGE				MT. SAVAGE, MARYLAND	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
AUGUSTINE		BRAILER		MARY PENDLEBERRY BRAILER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, <u>NO</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
		216 22 7071		SACRED HEART HOSPITAL		900 SETON DRIVE CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) congestive heart failure								2 wks	
4120 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 443X								20 yrs.	
(b) hypertensive heart heart disease									
DUE TO, OR AS A CONSEQUENCE OF									
(c) intestinal obstruction								2 wks.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
diabetes mellitus-generalized visceral failure									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
9-18-68		intestinal obstruction		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		none		none					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
		none		4-23-50, 19, to 9-21-68, 19, that (I) (we) last saw the deceased alive on Sept. 21, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. 3:45 PM					
22a. I certify that (I) (this hospital) attended the deceased from 4-23-50, 19, to 9-21-68, 19, that (I) (we) last saw the deceased alive on Sept. 21, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
		DR. JAMES P. HALLINAN						9-23-68	
23a. PHYSICIAN'S NAME (Type)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
DR. JAMES P. HALLINAN		9-24-68		ST. PATRICK'S CEMETERY		MT. SAVAGE, ALLEGANY, MD.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
JOSEPH R. DURST,		FROSTBURG, MD.		DATE		SEP 26 1968			



100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

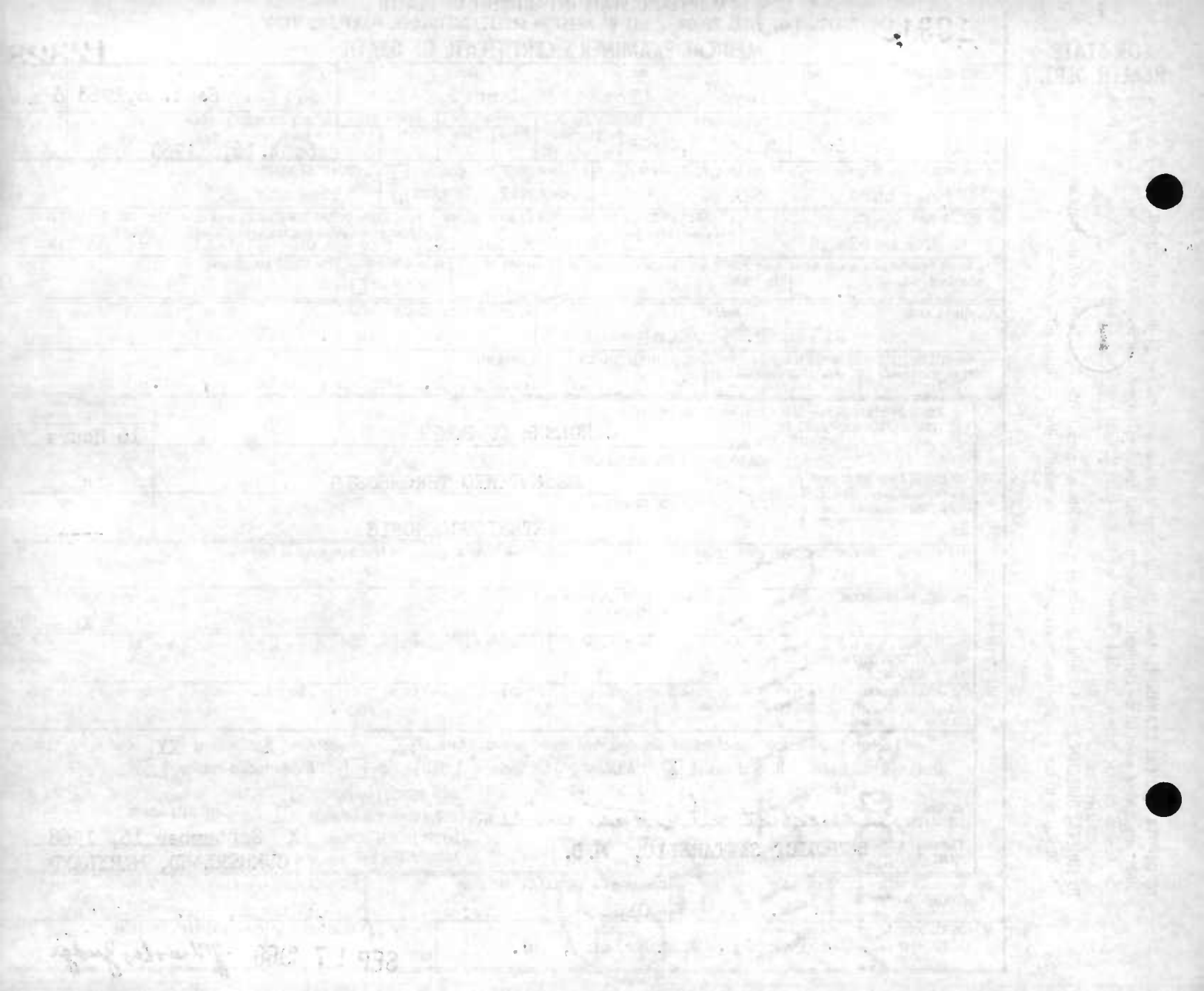
12318

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12328

1. DECEASED-NAME (Type or Print) First Middle Last Floyd Lloyd Carder			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year Sept. 16, 1968			2b. HOUR 6 a M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH July 28, 1893	6. AGE (In years last birthday) 75 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year Sept. 16, 1968 19	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Pipefitter-Railroad		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Oldtown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Silas P. Carder			15. MOTHER'S MAIDEN NAME First Middle Last Rose A. Deffenbaugh				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT ADDRESS Donald L. Carder, Oldtown, Md.-Son			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>444.2</u> <b>GANGRENE OF BOWEL</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { (b) <b>MESENTERIC THROMBOSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROSIS</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>16 Hours</b> " ----
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4500</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED September 16, 1968 ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 16, 1968		23c. NAME OF CEMETERY OR CREMATORY Oldtown Cemetery		23d. LOCATION (City or Town) (County) (State) Oldtown, Md. Allegany	
24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE SEP 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12318

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12329

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Charles Walter Carroll						Month Day Year			5 a.m.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	July 14, 1906	62 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year			7 a.m.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH			
Allegany		USA		WIDOWED		DIVORCED		Allegany Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			310 Harrison St.			None			None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Md.			Allegany			Cumberland			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER					
John W. Carroll			Anna Jane Walker			310 Harrison St.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
no						Mrs. Cecil Colbert, Cumberland, Md. - Sister					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:										Sudden	
IMMEDIATE CAUSE (a) Pulmonary Embolism, Massive											
DUE TO, OR AS A CONSEQUENCE OF											
4549 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										Varicosities of Lower Extremities --	
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
460X											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.				City or Town		County State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			Benedict Skitarelic, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			Benedict Skitarelic, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			September 18, 1968		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Cumberland, Maryland		
						ADDRESS (Street, city, town, or County)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Sept. 21, 1968		St. Patrick's Cemetery		Cumberland, Allegany, Md.					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, Md.						DATE SEP 20 1968		Charles Judge			

1828

1828

FOR THE  
FUTURE

on

1828

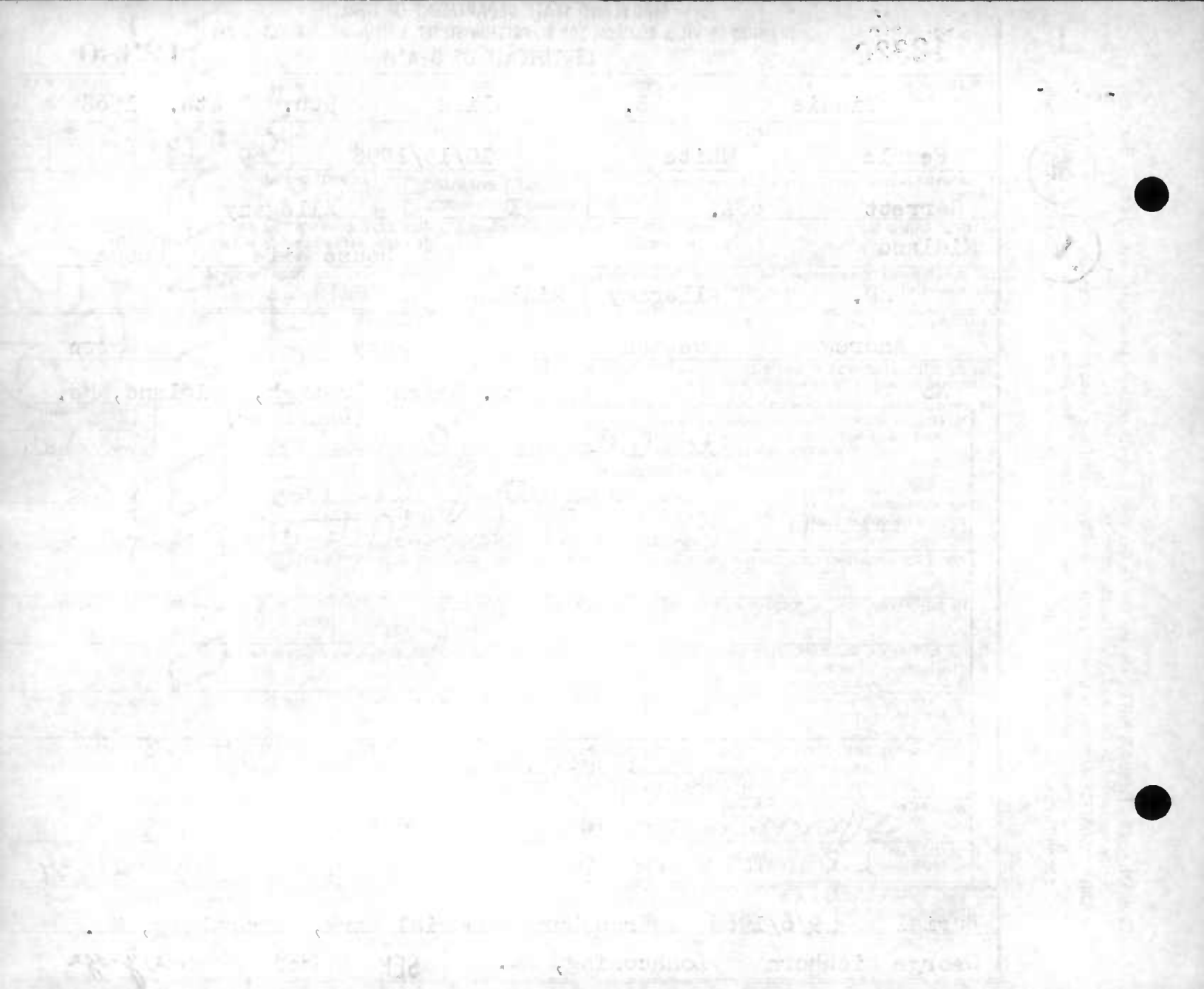
1828

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print) <b>Tinnie</b>		First	Middle	Lost	2a. DATE OF DEATH <b>9th.</b> Month <b>4th.</b> Year <b>1968</b>	2b. HOUR M	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>10/15/1898</b>			6. AGE (In years lost birthday) <b>69</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Garrett</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b> Md.			
10. CITY OR TOWN OF DEATH <b>Midland</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>House Wife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>	13b. COUNTY <b>Allegany</b>	13c. CITY OR TOWN <b>Midland</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
14. FATHER'S NAME <b>Andrew</b>	First	Middle	Lost	15. MOTHER'S MAIDEN NAME <b>Mary</b>	First	Middle	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name and rank (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Helen Blubaugh, Midland, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Advanced Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(Daughter) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b> <b>years</b> <b>years</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>4201</b>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 1, 1968</b> , to <b>Sept. 4, 1968</b> , that (I) (we) last saw the deceased alive on <b>Sept. 1, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>L.R. Miles, Jr.</b> MD DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>9.5.68</b>	
22d. PHYSICIAN'S NAME (Type) <b>L.R. MILES, JR., M.D.</b>			22e. ADDRESS <b>LONA CONING, MD. 21539</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9/6/1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park, Frostburg, Md.</b>		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <b>George Eichhorn</b>			ADDRESS <b>Lonaconing, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 6 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12321

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 23b, Film 404 9/20/68 km

CERTIFICATE OF DEATH

12321

1. DECEASED-NAME (Type or print) <b>Esther I Davis</b>			2a. DATE OF DEATH Month <b>Sept.</b> Day <b>12</b> Year <b>1968</b>			2b. HOUR <b>12</b> MIN. <b>00</b>					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>9/26/1906</b>		6. AGE (In years last birthday) <b>61</b> YRS.		IF UNDER 1 YEAR MONTHS <b>00</b> DAYS <b>00</b> HOURS <b>00</b> MIN. <b>00</b>			
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b> Md.					
10. CITY OR TOWN OF DEATH <b>Frostburg</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Miners Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>House Wife</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>Allegany</b>			13c. CITY OR TOWN <b>Lonaconing</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Charlestown, ST.</b>	
14. FATHER'S NAME First <b>John</b> Middle <b>Hendra</b> Last <b>Hausman</b>			15. MOTHER'S MAIDEN NAME First <b>Janet</b> Middle <b>Hausman</b> Last <b>Hausman</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Nelson Davis Lonaconing, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Posterior Coronary occlusion -</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HOV D - 3 yrs -</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State <b>Today, 2 hrs -</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>years -</b> , 19 <b>41</b> , to <b>9/12</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>9/12</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John B. Davis</b>			DEGREE <b>MD.</b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>9/12/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>John B. Davis, MD.</b>			22e. ADDRESS <b>Frostburg Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Sept. 16, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Lonaconing, MD.</b>		
24. FUNERAL DIRECTOR <b>George Eichhorn,</b>			ADDRESS <b>Lonaconing, Md.</b>			25a. REC'D BY REGISTRAR <b>SEP 16 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

10001

RECEIVED

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001

10001



10001

10001

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page 1. PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12322

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12332

1. DECEASED-NAME (Type or Print)			First <b>Harry</b>			Middle <b>Martin</b>			Last <b>Dicken</b>			2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> Sept. 11, 1968			2b. HOUR 6:20 a.m.		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>6-20-82</b>		6. AGE (In years last birthday) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year <b>September 11, 1968 19 7:10 a.m.</b>			2d. HOUR		
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>Allegany</b> Md.					
10. CITY OR TOWN OF DEATH <b>Cumberland</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Memorial Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Farmer</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>Allegany</b>				13c. CITY OR TOWN <b>Cumberland</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Route 3, Valley Road</b>			
14. FATHER'S NAME First Middle Last <b>Martin L. Dicken</b>						15. MOTHER'S MAIDEN NAME First Middle Last <b>Malinda Gurley</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>213-24-5283</b>				17. INFORMANT <b>Homer Dicken</b>				ADDRESS <b>Route #3 Cumberland, Md</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE HEMORRHAGIC PANCREATITIS</b> <b>5770</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>(Primary)</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 Hours</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>5870</b>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED									
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>September 11, 1968</b>									
				ADDRESS (Street, city, town, or county) <b>CUMBERLAND, MARYLAND</b>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>9-13-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Centenary Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>RT. 3 Cumberland Allegany Md.</b>							
24. FUNERAL DIRECTOR <b>H. Lee Silcox</b>				ADDRESS <b>404 Decatur St., Cumb., Md.</b>				25a. REC'D BY REGISTRAR <b>SEP 13 1968</b>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



12323

12333

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR		
Joseph (John) J. Dorn						9 19 68			3:45pM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
Male		White		April 9, 1900			68 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Maryland		USA					Allegany Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			330 Byrd Ave. (319 Caroline St.)			Retired Foreman			Textile		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 330 Byrd Ave. (319 Caroline Street)	
Md.			Allegany			Cumberland					
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
George Dorn						Matilda Britton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
						Mrs. Grace Dorn, Cumberland, Md.-Wife					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION											
4109 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? k			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from JULY, 1968, to 9-15, 1968, that (I) (we) lost the deceased alive on 9-15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		L. Michael Gahick				22c. DATE SIGNED		9-20-68			
22d. PHYSICIAN'S NAME (Type)		L. MICHAEL Gahick				22e. ADDRESS		BROODOCK MED GROUP CUMBERLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Sept. 23, 1968		SS. Peter & Paul Cemetery		Cumberland, Allegany, Md.					
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, Md.						DATE SEP 24 1968		J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

• • • • •

46

1802

373:34

100

Page 17

11. 2011-2012

1005-5884/01/0005-0000\$05.00/0

• 24 •

Dr. Caroline Street

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

12324

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12334

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Elizabeth Mackey Durst			2a. DATE OF DEATH Month Day Year September 30 1968			2b. HOUR 8:15A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 21, 1891		6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.			
10. CITY OR TOWN OF DEATH Near Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Baltimore Pike		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY ---			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 304 Cumberland Street	
14. FATHER'S NAME First Middle Last John George			15. MOTHER'S MAIDEN NAME First Middle Last Mary Stevenson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 214-05-4322		17. INFORMANT Address Md Mrs. Robert Altstetter, Balto Pike, Cumberland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 Diabetes mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 6-1, 1955, to 9-30, 1968, that (I) (we) last saw the deceased alive on 9-29, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ralph W. Ballin, M.D.				22c. DATE SIGNED 9-30-68					
22d. PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D.				22e. ADDRESS 62 Greene St., Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/2/1968		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Near Cumberland Alleg Md			
24. FUNERAL DIRECTOR Charles E. Hafer				25a. REC'D BY REGISTRAR OCT 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12325												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												12335											
1. DECEASED-NAME (Type or print) First Middle Last Piercy V. Durst												2a. DATE OF DEATH Month Day Year Sept. 21 1968												2b. HOUR M											
3. SEX M				4. RACE W				5. DATE OF BIRTH June 21, 1894				6. AGE (In years last birthday) 74 YRS.				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS. HOURS MIN.															
7a. BIRTHPLACE (State or foreign country) Md.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Allegany Md.																							
10. CITY OR TOWN OF DEATH Frostburg				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Miners Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer				12b. KIND OF BUSINESS OR INDUSTRY Own Farm																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Garrett				13c. CITY OR TOWN Frostburg				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET AND NUMBER R.D.																			
14. FATHER'S NAME First Middle Last Wesley Durst				15. MOTHER'S MAIDEN NAME First Middle Last Sarah Layman																															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. 220-38-0203				17. INFORMANT Address Charles Durst, Star Rt., Frostburg, Md.																											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE BRAIN SYNDROME</u> 401X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CIRCULATORY DISTURBANCE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYPERTENSIVE VASCULAR DISEASE</u> 4 hrs. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 444X																																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 444X																																			
19a. DATE OF OPERATION 9/20/68				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED VENTRAL HERNIA				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																											
22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 14 1968</u> , to <u>SEPT. 21, 1968</u> , that (I) (we) last saw the deceased alive on <u>SEPT. 20</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE G. Paige Strong								DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 9/21/68																							
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS																											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 9/24/68				23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery				23d. LOCATION (City or Town) (County) (State) Frostburg Allegany, Md.																							
24. FUNERAL DIRECTOR Ruth Newman				ADDRESS Grantsville, Md.				25a. REC'D BY - REGISTRAR SEP 27 1968				25b. REGISTRAR'S SIGNATURE [Signature]																							

12345

DETROIT, MICH.

1900

101

Acute Brain Syndrome

Circulatory Disturbance

Hypertensive Vascular Disease

1/2-1/3 Ventricular

Sept 20 12 30 PM

1/2-1/3 Ventricular

1/2-1/3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)  
30M REV. 1/68

12326		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12336	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH	
MARGARET			C		EMERICK	9 Month 24 Day 68 or 10:25 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)	
FEMALE		WHITE		6-26-91		77 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
PENNSYLVANIA		U.S.A.				ALLEGANY Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND		MEMORIAL HOSPITAL		Japanese employee			
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND		ALLEGANY		CUMBERLAND		617 MONTGOMERY AVENUE	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME	
JOSEPH				KREIGLINE		SARAH A KENNEL	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		
No			214-07-1993		MEMORIAL HOSPITAL CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hypertension and arterio-sclerotic</u> <u>4120</u> DUE TO, OR AS A CONSEQUENCE OF <u>cardio-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) <u>Large carcinoma of right ovary</u> <u>6 x 20</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>443X</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
9-17-68		Carcinoma of ovary		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>9-12</u> , 19 <u>68</u> , to <u>9-24</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>9-23</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Donald B. Grove</u>				22c. DATE SIGNED <u>9-25-68</u>			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
DR. DONALD B. GROVE				CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		Sept. 27, 1968		Hyndman Cemetery		Hyndman, Bedford Co., Pa.	
24. FUNERAL DIRECTOR'S ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	
<u>Walter H. Fay Jr.</u> Hyndman, Penna.				SEP 27 1968		<u>Charles Judge</u>	

TERACON

15-52-2

ALWAYS USE

DATE OF BIRTH: 1907-10-10

DR. DONALD B. GROVE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
123327									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Martha			N. Finley			September 10 68			M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		11/24/1891		78		YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Allegany Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Frostburg			Miners Hospital			House Work			Own Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Md			Allegany			Lonaconing		West Main Street	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Albert Crowe			Isabelle Dunn						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
no					Ernest Finley		Lonaconing, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF <u>Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF <u>Generalized Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>years</u> <u>year</u>	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 10</u> , 19 <u>64</u> , to <u>Sept 10</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Sept 10</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>L.R. Miles</u>					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9-11-68
22d. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.					22e. ADDRESS LONA CONING MD 21539				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		9/12/68		Frostburg Memorial Park			Frostburg A. Md		
24. FUNERAL DIRECTOR				ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
George Eichhorn				Lonaconing, Md.			DATE SEP 16 1968		Charles Judge





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <b>JANETTE T. GEORGE</b>						2a. DATE OF DEATH Month Day Year <b>09 13 68</b>			2b. HOUR A <b>12:20</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>12-30-93</b>			6. AGE (In years lost birthday) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY COUNTY</b> Md.					
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SACRED HEART HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>LONA CONING</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>LONA CONING, MD. STATE ROUTE 36 NORTH.</b>		
14. FATHER'S NAME First Middle Last <b>ROBERT RUSSELL</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>( TENNETT ) JANETTE RUSSELL</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>213-01-6074</b>		17. INFORMANT Address <b>SACRED HEART HOSPITAL, CUMBERLAND, MD. 21502</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>atherosclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b> <b>1 year</b> <b>4 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>9-1-</u> , 19 <u>68</u> , to <u>9-12-</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>9-12-</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>L. Brings</i>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>9-14-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>L. BRINGS, M.D.</b>						22e. ADDRESS <b>57 GREENE ST., CUMBERLAND, MD. 21502</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/15/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Frostburg, Md.</b>				
24. FUNERAL DIRECTOR <b>LONA CONING, MD.</b>						ADDRESS <b>EICHORN FUNERAL SERVICE, 8 E. MAIN ST.,</b>		25a. REC'D BY REGISTRAR <b>SEP 16 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (4-64)  
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last <b>DELORES L. GRABENSTEIN</b>					2a. DATE OF DEATH Month Day Year <b>9 17 68</b>			2b. HOUR P <b>4:15 M</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>4 22 89</b>		6. AGE (In years last birthday) <b>79 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY Md.</b>				
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SACRED HEART HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>BOX 363 -WINCHESTER ROAD</b>	
14. FATHER'S NAME First Middle Last <b>HENRY METZNER</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>ELIZA MOODY GRABENSTEIN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>			16b. SOCIAL SECURITY NO. <b>220-34-1301</b>		17. INFORMANT <b>900 SETON DRIVE CUMBERLAND, MARYLAND</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL FAILURE</b> <b>4/129</b> DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4200</b> (b) <b>CEREBRAL ARTERIOSCLEROSIS WITH CATATONIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 MO.</b> <b>3 YRS.</b> <b>4 MO.</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>UREMIA-GENERALIZED VISCERAL FAILURE-SENILITY</b>										
19a. DATE OF OPERATION <b>NONE</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> #		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NONE</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <b>NONE</b>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) <b>NONE</b>						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b>NONE</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>SEPT. 18 1961 SEPT. 17, 68</b>						
22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT. 17, 19 68</b> to <b>SEPT. 17, 19 68</b> , that (I) (we) last saw the deceased alive on <b>SEPT. 17, 19 68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. <b>415 PM</b>										
22b. SIGNATURE <b>James P. Hallinan</b>					DEGREE ATTENDING PHYS. # MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>9-18-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>DR. JAMES P. HALLINAN</b>					22e. ADDRESS <b>140 BEDFORD ST. -CUMBERLAND, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>9/20/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. MICHAEL'S CEMETERY FROSTBURG, ALLEGANY, MD.</b>		23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG, ALLEGANY, MD.</b>				
24. FUNERAL DIRECTOR <b>MARILOU M. SOWERS, HAFFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG</b>										
25a. REC'D BY REGISTRAR <b>SEP 23 1968</b>					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil, in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12330

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12340

1. DECEASED-NAME (Type or Print)			First Amanda			Middle Emma			Last Grenoble			2a. DATE KNOWN OF DEATH Month Day Year 9-21-68			11:00 AM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH March 11, 1887		6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year Sept. 21, 1968			11:00 AM				
7a. BIRTHPLACE (State or foreign country) Cumberland,				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Allegany				Md.			
10. CITY OR TOWN OF DEATH Cumberland,				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. Press Feeder				12b. KIND OF BUSINESS OR INDUSTRY Printing							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Allegany				13c. CITY OR TOWN Cumberland,				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 210 Maryland Ave.					
14. FATHER'S NAME First Middle Last Ulrich -- Wiebel						15. MOTHER'S MAIDEN NAME First Middle Last Bertha C. Lehman													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 214-05-4105				17. INFORMANT ADDRESS Mr. Frank L. Wiebel 718 Oldtown Rd. Cumb. Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4109</u> CORONARY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Sclerosis</u>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>45 minutes</u> <u>45 Minutes</u> ----					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>						21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED							
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						September 21, 1968							
						ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 9/25/68				23c. NAME OF CEMETERY OR CREMATORY Rose Hill Mausoleum				23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.							
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland						ADDRESS						25a. REC'D BY REGISTRAR DATE SEP 26 1968				25b. REGISTRAR'S SIGNATURE J Charles Judge			





**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12331

MARYLAND DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12341

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Mary Frances Guy						Month Day Year			2d. HOUR		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		
Female			White			March 8, 1919			49 YRS.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland			U.S.A.						Allegany Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Westernport			130 Church St.								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland			Allegany			Westernport			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER					
First Middle Last			First Middle Last			130 Church St.					
James A. Walsh Jr.			Nora Ryan								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No						Ethel Ann Guy			130 Church St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Gunshots DUE TO, OR AS A CONSEQUENCE OF (Homicide) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 981X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			Benedict Skitarelic, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			Benedict Skitarelic, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			September 29, 1968		
						ADDRESS (Street, city, town, or county)			Cumberland, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			Oct. 2, 1968			St. Peter's			Westernport Allegany Md		
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR		
Wm. H. Fredlock						Jones St.			DATE OCT 7 1968		
									25b. REGISTRAR'S SIGNATURE Charles Judge		



0001-7500

*Myrica*

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12332

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12342

1. DECEASED-NAME (Type or Print) <b>Ralph R. Guy</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>Sept.</b> Day <b>29</b> Year <b>1968</b>			2b. HOUR <b>8:30</b> a.m.			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>May 2, 1918</b>	6. AGE (In years last birthday) <b>50</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b>	DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b>	MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>September</b> Day <b>29</b> Year <b>1968</b>	2d. HOUR <b>8:30</b> p.m.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b>			
10. CITY OR TOWN OF DEATH <b>Westernport</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>130 Church St.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Clerk</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Hardware</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Allegany</b>			13c. CITY OR TOWN <b>Westernport</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First <b>John</b> Middle <b>Guy</b> Last <b>Boggs</b>			15. MOTHER'S MAIDEN NAME First <b>Ethel</b> Middle <b>Boggs</b> Last <b>Boggs</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WW II</b>			
16b. SOCIAL SECURITY NO. <b>220-10-1319</b>			17. INFORMANT <b>Ethel Ann Guy</b>			17. ADDRESS <b>130 Church St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot of Head</b> DUE TO, OR AS A CONSEQUENCE OF <b>(Suicide)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>976x</b>									
19a. DATE OF OPERATION <b>-</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>Sept. 29, 1968</b>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
			ADDRESS (Street, city, town, or county) <b>UMBERLAND, MARYLAND</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Oct. 2, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's</b>			
23d. LOCATION (City or Town) (County) (State) <b>Westernport Allegany Md.</b>			25a. REC'D BY REGISTRAR <b>OCT 7 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
24. FUNERAL DIRECTOR <b>Fredlock</b>			ADDRESS <b>Jones St. Piedmont, W. Va.</b>						

092 1 100

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item 13 Film G405 10/3/68 Jk									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
PEARL			HAY			9 Month 23 Day 88 Year		12:10 P	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
FEMALE		WHITE		3-21-86		82 RS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
PENNSYLVANIA		U.S.A.				ALLE GANY Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND,			MEMORIAL HOSPITAL						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD. Pa.			ALLEGANY					RD 1 CUMBERLAND, MARYLAND	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
NORMAN D HAY			AGNES			GLOTEELTY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
						MEMORIAL HOSPITAL			
						Address CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease, generalized</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Generalized arteriosclerosis</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(c)									
<u>Old Cerebrovascular accident, Mild Diabetes Mellitus</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>16 Aug</u> , 19 <u>68</u> , to <u>23 Sept</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>23 Sept</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Andrew Stasko MD</u>						DEGREE		22c. DATE SIGNED	
						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		9-27-68	
22d. PHYSICIAN'S NAME (Type) <u>DR. W. A. VAN ORMER</u>						22e. ADDRESS CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<u>BURIAL</u>			<u>SEPT 27, 1968</u>			<u>ST. PAUL CEMETERY</u>		<u>MEYERSDALE RD 1 Som Co. PA</u>	
24. FUNERAL DIRECTOR <u>PRICE FUNERAL HOME</u> ADDRESS <u>325 MAIN ST</u> <u>M. R. Leekandy</u> <u>MEYERSDALE, PA</u>						25a. REC'D BY REGISTRAR DATE <u>SEP 30 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

103387

PEARL HARBOR MAY 28 1942

WHITE  
FEMALE  
U.S. ARMY

GENERAL HOSPITAL

GENERAL HOSPITAL

GENERAL HOSPITAL

GENERAL HOSPITAL

GENERAL HOSPITAL

GENERAL HOSPITAL

GENERAL HOSPITAL

GENERAL HOSPITAL

GENERAL HOSPITAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>CLARA A. HECK</b>					2a. DATE OF DEATH Month <b>09</b> Day <b>20</b> Year <b>68</b>		2b. HOUR <b>10A</b> M		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>03-16-08</b>		6. AGE (In years last birthday) <b>60</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md.			
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital) <b>SACRED HEART HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during life, even if retired.) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR <b>NONE</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>OLDTOWN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>ROUTE 1</b>	
14. FATHER'S NAME First <b>DANIEL</b> Middle <b>WILLIAM</b> Last <b>LEASURE</b>			15. MOTHER'S MAIDEN NAME First <b>RUTH</b> Middle <b>WILMA</b> Last <b>PIPER</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>HOSP., RECORD</b> Address <b>900 SETON DR., CUMB., MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke</b> <b>436.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b> <b>5 years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>334X</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>9-11-1968</b> to <b>9-20-1968</b> , that (I) (we) last saw the deceased alive on <b>9-19-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>L. Brings</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>9-20-68</b>					
22d. PHYSICIAN'S NAME (Type) <b>DR. L. BRINGS</b>				22e. ADDRESS <b>57 GREENE ST., CUMBERLAND, MD. 21502</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>9/23/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Near Cumberland Alleg Md</b>			
24. FUNERAL DIRECTOR <b>HAFER'S</b> <b>BALTIMORE AVE., CUMB., MD.</b>				25a. REC'D BY REGISTRAR <b>SEP 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

03 30 42 104

HECK

CLARA

03-16-02 WHITE  
ALLEGANY Y USA  
ALLEGANY

HOUSEHOLD SACRED HEART HOSPITAL CUMBERLAND

ROUTE 1 ALLEGANY DISTRICT HARYLAND

PIPER LEASURE BUTH DANIEL

NO NONE HOSP., RECORD, GOD SETIN DR., CURR., NO.

DP, I, BRINGS 27 OFENE ST., CUMBERLAND, MD. 21202

HARRIS TAILORING AND CURR., MD.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1514  
30M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
12335					12345					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
First <del>XXXXXX</del> HOMER Middle S. Last HIGGINS					Month 09 Day 20 Year 68			1:22 P M		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 06-13-08		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		IF UNDER 24 HRS. HOURS MIN.		
MARYLAND		USA				ALLEGANY		Md.		
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and city)			12a. USUAL OCCUPATION (Kind of work done during last 12 months, even if retired.)			12b. KIND OF BUSINESS OR OCCUPATION	
SACRED HEART HOSPITAL			SUPERVISOR			PUBLIC SCHOOLS				
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MARYLAND			ALLEGANY		LA VALE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1264 VOCKE RD.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last PATRICK HIGGINS			First Middle Last ELLA SCOTT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT					
W.W. 2			220-16-6974		HOSP., RECORD 900 SETON DR., CUMB., MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA 4120 DUE TO, OR AS A CONSEQUENCE OF (b) HASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 443X										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 9-20-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Dr. Matthew L. Kaufman MD						22c. DATE SIGNED 9-20-68				
22d. PHYSICIAN'S NAME (Type) DR. MATTHEW L. KAUFMAN						22e. ADDRESS 912 SETON DR., CUMB., MD. 21502				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL			9-23-1968		HILLGREST BURIAL PARK			CUMBERLAND ALLEG. MD.		
24. FUNERAL DIRECTOR DURST FUNERAL HOME						25a. REC'D BY REGISTRAR DATE SEP 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		
FROSTBURG, MD.										

100-10000

100-10000

2

WILLIAM JONES

100-10000

100-10000

WHITE

WHITE

ALABAMA

100-10000

ALABAMA

SUBJECT

SHORT REPORT

CLINICAL

100-10000

ALABAMA

ALABAMA

SCOTT

ALTA

WILLIAM

PATRIC

100-10000

100-10000

CIV

100-10000

100-10000

100-10000

100-10000

100-10000

100-10000

100-10000

100-10000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

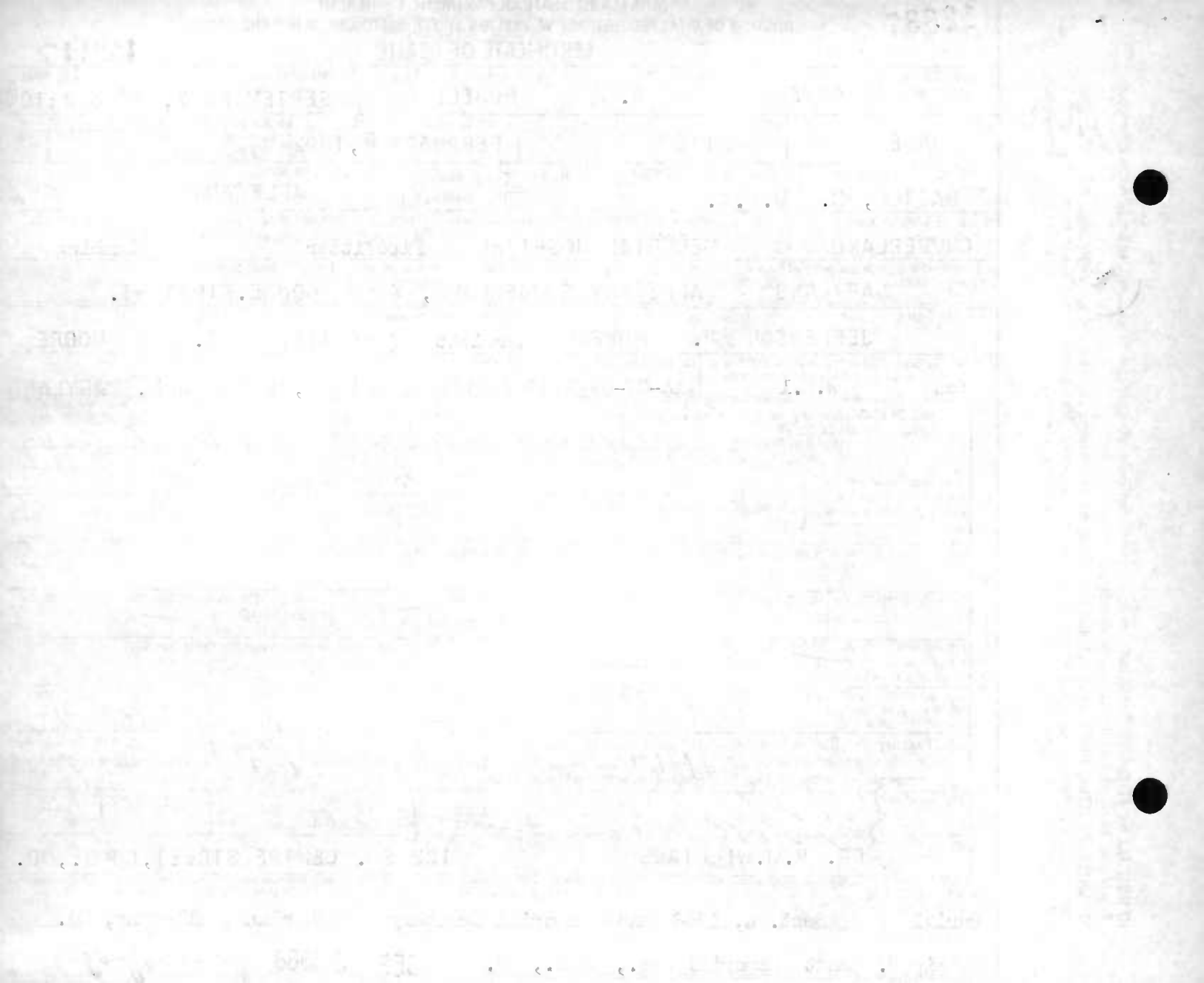
12336		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12346	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last LUCY E. HOLCOMB			2a. DATE OF DEATH Month Day Year SEPTEMBER 11, 1968			2b. HOUR P.M. 4:12	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 10-3-95		6. AGE (In years lost birthday) 72 YRS.	
7a. BIRTHPLACE (State or foreign country) W.VA.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done usual most of working life, even if retired.) WIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE PENNA.		13b. COUNTY BEDFORD		13c. CITY OR TOWN BEDFORD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER RT. 3		14. FATHER'S NAME First Middle Last JAMES W. JORDAN		15. MOTHER'S MAIDEN NAME First Middle Last FANNIE S. SHOVER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 201-32-7973		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the</u> 180X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>177X</u> (b) <u>Carcinoma of cervix</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr. 2 yrs.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Obesity</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 11, 1968</u> to <u>Sept 11, 1968</u> , that (I) (we) last saw the deceased alive on <u>Sept 11, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>DR. DONALD B. GROVE</u>		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) DR. DONALD B. GROVE		22e. ADDRESS 122 S. CENTRE ST., CUMB. MD.					
23a. BURIAL, CREMATION, BURNING (Specify)		23b. DATE 9/14/68		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland	
24. FUNERAL DIRECTOR H. Lee Silcox Cumberland, Maryland 21502				25a. REC'D BY REGISTRAR DATE SEP 16 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

DATE: 4-2-56 NAME: [illegible] ADDRESS: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12337										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										12347									
1. DECEASED-NAME (Type or print) First Middle Last ORVEL R. HOWELL										2a. DATE OF DEATH Month Day Year SEPTEMBER 2, 1968										2b. HOUR A.M. 2:10									
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH FEBRUARY 8, 1892			6. AGE (In years last birthday) 76 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.														
7a. BIRTHPLACE (State or foreign country) BARTON, MD.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY Md.																				
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Pipewriter			12b. KIND OF BUSINESS OR INDUSTRY Plumbing																				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 608 E. FIRST ST.																	
14. FATHER'S NAME First Middle Last JEFFERSON R. HOWELL			15. MOTHER'S MAIDEN NAME First Middle Last Harriett (HATTIE) E. MOORE																										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes			16b. SOCIAL SECURITY NO. W.W.1			17. INFORMANT 214-07-6973A			ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Brain Aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Stroke</u> 151.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 151X																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State Camp School Alle Md																							
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 24</u> , 19 <u>65</u> , to <u>9/2/65</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>9/2/65</u> , 19 <u>65</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>R. J. Williams</u>			22c. DATE SIGNED <u>9/4/65</u>			22d. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS			22e. ADDRESS 122 SO. CENTRE STREET, CUMB., MD.																				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Sept. 4, 1968			23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery			23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.																				
24. FUNERAL DIRECTOR Philip B. Wendt			ADDRESS Memorial Ave., Cumb., Md.			25a. REC'D BY REGISTRAR SEP 5 1968			25b. REGISTRAR'S SIGNATURE J Charles Judge																				



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
10M REV. 1/68

12338

MARYLAND DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12348

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED			Month Day Year			2b. HOUR							
Clarence			Edward			Jackson			9-26-68			4:55 p M							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR				
Male		White		Nov. 1, 1895		72 YRS		10 25				September 26, 1968			4:55 p M				
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH				Md.			
New Creek, W. Va.				U.S.A.								Allegany							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY							
Cumberland, Md.				Sacred Heart Hospital-DOA				Retired Carpenter											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER					
Md.				Allegany				Rawlings				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rawlings Heights					
14. FATHER'S NAME First Middle Last						15. MOTHER'S MAIDEN NAME First Middle Last													
Charles Edawrd Jackson						Katherine Louise Ashby													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS							
Yes						WWI Army						216-09-8531 Mrs. Elma Jackson Rawlings, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____														(Wife)		CORONARY OCCLUSION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
4109																CORONARY SCLEROSIS		--	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <i>Benedict Skitarellic</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED							
EXAMINER'S NAME (Type)						BENEDICT SKITARELIC, M.D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> September 26, 1968							
												ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)									
Burial				9-29-68		Ebenezer Cemetery				Near Romney, W. Va.									
24. FUNERAL DIRECTOR <i>Harold W. McKenzie Keyser, W. Va.</i>												25a. REC'D BY REGISTRAR DATE SEP 30 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



FOR STATE  
DEPARTMENT

100-302

MEDICAL EXAMINER, DISTRICT OF COLUMBIA

100-302

Clarence E. Jackson 100-302-10000

White male, 100-302-10000

Allegation

Second floor, 100-302-10000

100-302-10000

100-302-10000

100-302-10000

100-302-10000

100-302-10000

100-302-10000

100-302-10000

100-302-10000

100-302-10000

100-302-10000

100-302-10000

100-302-10000

100-302-10000

100-302-10000

100-302-10000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1. DECEASED-NAME (Type or print)		First <b>LEMUEL</b>	Middle <b>G.</b>	Last <b>KIRK</b>	2a. DATE OF DEATH Month <b>9</b> Day <b>25</b> Year <b>1968</b>		b. HOUR <b>6:40</b> M		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>9-25-1880</b>		6. AGE (In years last birthday) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>PA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md.			
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSP.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Contractor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>State Roads</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1825 FREDERICK ST.,</b>	
14. FATHER'S NAME First <b>LEMUEL</b>		Middle <b>KIRK</b>		Last <b>ALICE</b>		15. MOTHER'S MAIDEN NAME First <b>CHESTNUT</b>		Middle <b>CHESTNUT</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MEMORIAL HOSPITAL-CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sudden Cardiac arrest</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Coronary heart failure</b> (b) <b>Myocardial infarction, anteroseptal</b> (c) <b>3 weeks</b> <b>16 Aug. 68</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4201</b> <b>A.S. Coronary disease 5 years</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>1 Aug.</b> , 19 <b>68</b> , to <b>25 Sept.</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>22 Sept.</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>W. A. Van Ormer, M.D.</b>				DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>29 Sept. 68</b>	
22d. PHYSICIAN'S NAME (Type) <b>DR. W. A. VAN ORMER</b>				22e. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Sept. 28, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Presbyterian Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Warfordsburg, Pa.</b>			
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>OCT 3 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988



1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV.

12340		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12350			
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH		2b. HOUR	
First		Middle		Last		Month		Day, Year	
WILLIAM		B.		KISER		SEPTEMBER		2, 1968	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR	
MALE		WHITE		Nov. 5, 1915		52 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
KEYSER, W. VA.		U.S.A.				ALLEGANY Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND, MD.		MEMORIAL HOSPITAL, CUMB., MD.		Brakeman		B+O RR			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		CUMBERLAND				496 WILLIAMS STREET	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT	
First		Middle		Last		Address			
CHARLES E.		KISER		MAUDE		BLAIR			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic disease of the liver, Asites, Pancreatitis</u> 571.9 DUE TO, OR AS A CONSEQUENCE OF <u>Sandwich</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		Unknown over 2 yrs.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 5810									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
None									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>8-24</u> , 19 <u>68</u> , to <u>Sept 2</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>Sept 1</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. REC'D BY REGISTRAR	
Carter Brinsfield		Oct 3 1968		DR. C. BRINSFIELD		401 DECATUR STREET, CUMBERLAND, MD.		25b. REGISTRAR'S SIGNATURE	
								25a. REC'D BY REGISTRAR	
								25b. REGISTRAR'S SIGNATURE	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		Sept 5/68		Sunset Memo. Ph.		Cumberland Allegany Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Louis Stein Inc.		Cumb. Md.		SEP 5 1968		Charles Judge			

11-3-30

RECORDS OF DEATH

1930

WILLIAM J. RYAN

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 2101 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div> <div>12351</div> <div>Item #13c.e, Film G105 10/18/68</div> </div>									
1. DECEASED-NAME (Type or print)				2a. DATE OF DEATH		2b. HOUR			
CHARLES W. LANGLEY				SEPTEMBER 20, 1968		10:50 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. IF UNDER 1 YEAR	
MALE		WHITE		4-15-1912		56 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U. S. A.				ALLEGANY		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		MEMORIAL HOSPITAL							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		CUMBERLAND		<input type="checkbox"/> NO <input type="checkbox"/>		59 McCulloh St.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
HOWARD		ISABELLE KERR		no				MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. MEDICAL CERTIFICATION		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY:				6 days					
IMMEDIATE CAUSE (a) 5621 SHOCK									
DUE TO, OR AS A CONSEQUENCE OF (b) PERITONITIS									
DUE TO, OR AS A CONSEQUENCE OF (c) DUE to Diverticulitis									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
5721 Right hemiparesis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town		County State	
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No.					
22a. I certify that (I) (the hospital) attended the deceased from 9-18, 1968, to 9-20, 1968, that (I) (we) last saw the deceased alive on 9-20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
Andrew Stasko MD		9-21-68							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
DR. ANDREW STASKO		401 DECATUR ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, or other disposition		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		9/23/68		Old Coney Cemetery		Lonaconing		A. Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
George Eichhorn		Lonaconing, Md.		SEP 24 1968		Charles Judge			

STATE OF TEXAS

COUNTY OF DALLAS

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) <b>WOODROW</b>			First <b>E.</b> Middle <b>LA RUE</b> Last			2a. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>25</b> Year <b>68</b>			2b. HOUR <b>8:10A</b>			
3. SEX <b>MALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>11/15/15</b>			6. AGE (In years last birthday) <b>52</b> YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>			7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>ALLEGANY CO.,</b> Md.			
1d. CITY OR TOWN OF DEATH <b>CUMBERLAND, MD.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SACRED HEART HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>SHIPPING CLERK</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>SPRINGFIELD TIRE CO.</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>PENNA.</b> COUNTY <b>SOMERSET</b>			13c. CITY OR TOWN <b>MEYERSDALE</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>630 BROADWAY</b>			
14. FATHER'S NAME First <b>FRANK</b> Middle <b>LA RUE</b> Last			15. MOTHER'S MAIDEN NAME First <b>ELsie</b> Middle <b>ELsie</b> Last <b>PYLE</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>YES</b> (If yes give war or dates of service) <b>7/45 TO 6/46</b>			16b. SOCIAL SECURITY NO. <b>193-01-7994</b>			17. INFORMANT <b>PATIENT'S HOSPITAL CHART</b> Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURE ESOPHAGEAL VARRICES</b> <b>5710</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>LAENNE'S CIRRHOSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 YRS</b>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>5811 DUODENAL ULCER</b>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE</b> , 19 <b>68</b> , to <b>25 Sept</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>25 SEPT 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>[Signature]</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>9-26-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>BRADDOCK MEDICAL GROUP</b> <b>L. MICHAEL GLICK, M. D.</b>						22e. ADDRESS <b>912 SETON DRIVE, CUMBERLAND, MD. 21502</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>SEPT 28, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>UNION CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>MEYERSDALE SOMERSET PA</b>			
24. FUNERAL DIRECTOR <b>M. R. Leckornly</b>						ADDRESS <b>325 MAIN ST MEYERSDALE, PA</b>			25a. REC'D BY REGISTRAR DATE <b>SEP 30 1968</b>			
									25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12343 CERTIFICATE OF DEATH 12353											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
CLYDE			E.			LASHLEY			Month Day Year P.M.		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		
MALE			WHITE			12-25-1898			2069 YRS.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH		
PENN.			U. S. A.						ALLEGANY Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			MEMORIAL HOSPITAL			Clerk			Grocery Store		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
MD.			ALLEGANY			CUMBERLAND			13e. STREET AND NUMBER		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
LORENZO			LASHLEY			AMY			SCHRIVER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
						MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Cerebral aneurysm with rupture</i>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <i>retention</i>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
163X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
			HOUR A.M. Month Day Year P.M.								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 4, 1968</i> to <i>Sept 4, 1968</i> , that (I) (we) last saw the deceased alive on <i>Sept 4, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE			22c. DATE SIGNED		
<i>Dr. Blane Schindler</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			<i>9/7/68</i>		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
DR. BLANE SCHINDLER						43 GREENE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			Sept. 7, 1968			Sunset Memorial Park			Cumberland, Allegany, Md.		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
James F. Scarplli, Cumberland, Md.						SEP 10 1968			<i>J. Charles Judge</i>		



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12344

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12354

1. DECEASED-NAME (Type or Print)			First <b>Calton</b>			Middle <b>R.</b>			Last <b>Lepley</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>Sept.</b> Day <b>3,</b> Year <b>1968</b>			2b. HOUR <b>1:40p M</b>								
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Aug. 20, 1910</b>		6. AGE (In years lost birthday) <b>58</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b>		IF UNDER 24 HRS DAYS <b>0</b>		HOURS <b>0</b>		MIN <b>0</b>		2c. DATE PRONOUNCED DEAD Month <b>September</b> Day <b>3,</b> Year <b>1968</b>			2d. HOUR <b>1:40p M</b>				
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>Allegheny</b>						Md.					
10. CITY OR TOWN OF DEATH <b>Cumberland</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Sacred Heart Hosp.</b>								12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Penna.</b>				13b. COUNTY <b>Somerset</b>				13c. CITY OR TOWN <b>Hyndman</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RD#1</b>									
14. FATHER'S NAME First <b>Norman</b> Middle <b>Lepley</b> Last <b></b>						15. MOTHER'S MAIDEN NAME First <b>Hanna</b> Middle <b>Troutman</b> Last <b></b>																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16b. SOCIAL SECURITY NO. <b>194-16-5640</b>				17. INFORMANT ADDRESS <b>Mrs. Calton Lepley, Hyndman, Pa RD#1</b>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLISM, MASSIVE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>916X</b> (b) <b>FRACTURE OF RIGHT ANKLE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> <b>5 DAYS</b>																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>910.1</b>																							
19a. DATE OF OPERATION <b></b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b></b>								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b></b>				21b. TIME OF INJURY Month, Day, Year HOUR <b>8:00 P.M.</b> DATE <b>8-29-68</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) <b>Tree fell on leg</b>															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Neighbors Farm</b>				21f. LOCATION Street or R.F.D. No. City or Town County State <b>Rt. #1 Hyndman, Bedford, Pennsylvania</b>															
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>September 3, 1968</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>Sept. 7, 1968</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Madley Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Buffalo Mills, Pa. RD#1</b>											
24. FUNERAL DIRECTOR <b>Harvey N. Ziegler</b>				ADDRESS <b>Hyndman, Pa.</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 9 1968</b>				25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>											

1981

MEMORANDUM FOR THE RECORD

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981

1981



FOR STATE  
HEALTH DEPT.

12345

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12355

1. DECEASED-NAME (Type or Print)		First George		Middle Ray		Last Light		2a. DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Sept. 5, 1968 Day Year			2b. HOUR 3 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH Nov. 6, 1910		6. AGE (In years last birthday) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month September 5, 1968 Day Year		2d. HOUR 3 P.M.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.						
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital--DOA				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Manager			12b. KIND OF BUSINESS OR INDUSTRY Theatre			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 706 Avondale Ave.				
14. FATHER'S NAME Elmer		First Middle Last Light		15. MOTHER'S MAIDEN NAME Mary Twigg		First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Kathleen Light, Cumberland, Md.--Wife						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4109</u> Coronary Occlusion Sudden DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Sclerosis											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4201</u>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED September 5, 1968		
ADDRESS James F. Scarpelli, Cumberland, Md.		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery		23d. LOCATION (City or Town) Cumberland		(County) Allegany		(State) Md.		25a. REC'D BY REGISTRAR SEP 10 1968		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 8, 1968		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery		23d. LOCATION (City or Town) Cumberland		(County) Allegany		(State) Md.		
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR SEP 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge						

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



1200

MEDICAL EXAMINER 1st CLASS OF INDIA

FOR THE

Ernest Hartman

DEPT. OF HEALTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)		First LENA		Middle G.		Last LINABURG		2a. DATE OF DEATH Month Day Year SEPTEMBER 5, 1968 12:22 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 2-20-05		6. AGE (In years lost birthday) 63 YRS.		2b. HOUR 12:22 PM	
7a. BIRTHPLACE (State or foreign country) W. VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY CO.		Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. CITY OR TOWN ALLEGANY		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 26 W. FIRST STREET			
14. FATHER'S NAME First Middle Last HENRY WHITE		15. MOTHER'S MAIDEN NAME First Middle Last ADA (RAINES) HAINES							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatoid Arthritis</u> 428X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocarditis &amp; Decompensation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1966 4 mo 5 yr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 1962, to <u>Sept. 5</u> , 1968, that (I) (we) last saw the deceased alive on <u>Sept. 5</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Clayton L. Burnett</u>		22c. DATE SIGNED 9/6/68		22d. PHYSICIAN'S NAME (Type) DR. C.E. DURRETT		22e. ADDRESS 236 VIRGINIA AVE., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 8, 1968		23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE SEP 10 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

100-100000

SEP 14 1960 11:55 AM

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

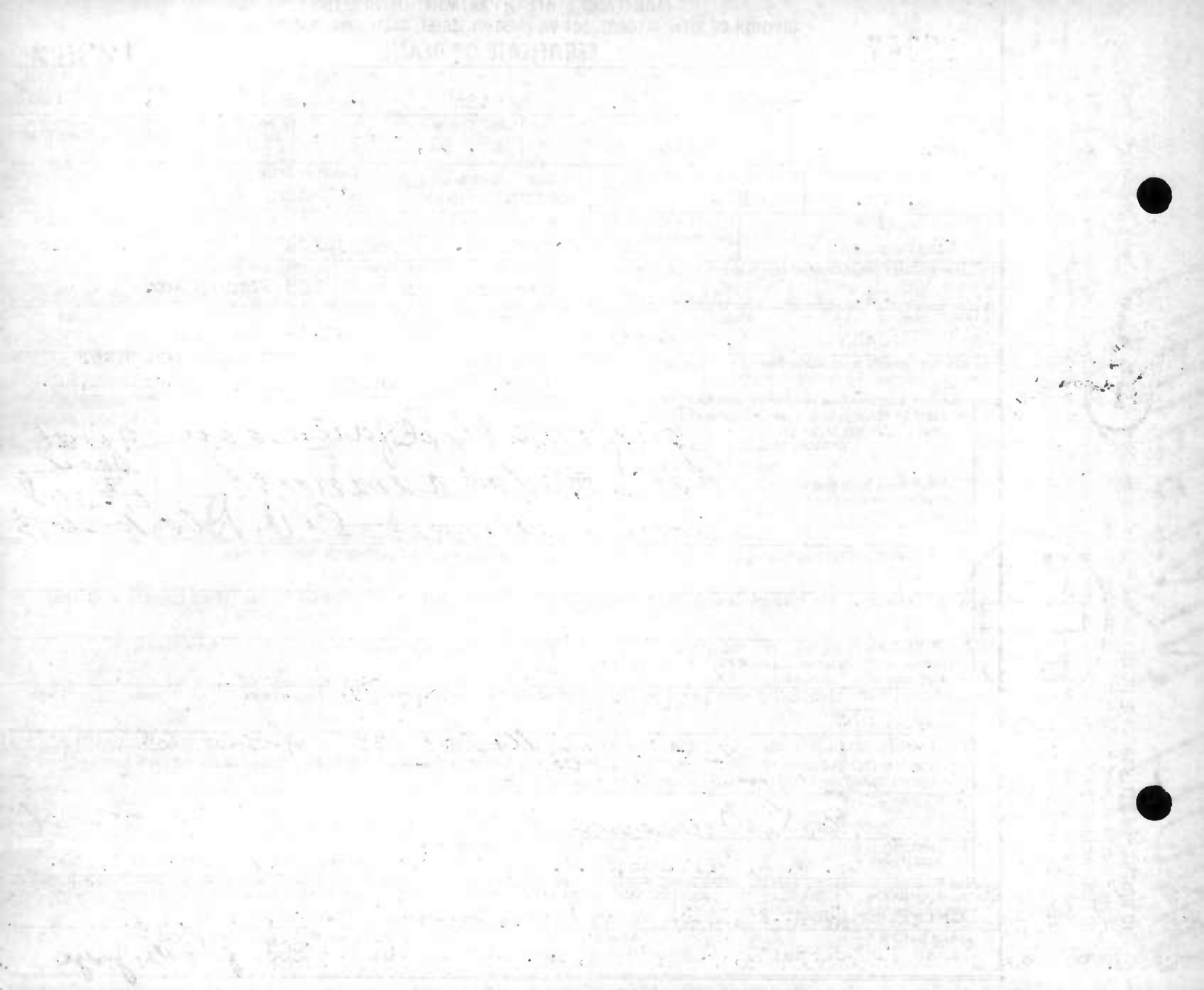
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12347

CERTIFICATE OF DEATH

12357

1. DECEASED-NAME (Type or print) <b>Minnie C. Martin</b>			2a. DATE OF DEATH Month <b>Sept.</b> Day <b>26</b> Year <b>1968</b>			2b. HOUR <b>5:00 P</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Oct. 31, 1882</b>		6. AGE (In years last birthday) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7b. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b> Md.				
10. CITY OR TOWN OF DEATH <b>Cumberland</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>108 Fourth St.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>108 Fourth St.</b>	
14. FATHER'S NAME First <b>John</b> Middle <b>O.</b> Last <b>Saville</b>			15. MOTHER'S MAIDEN NAME First <b>Sallie</b> Middle <b>Shanholtz</b> Last <b>Daughter</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Rubye Puffinburger, Cumberland, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4129 Digestive heart failure on basis of a fat advanced</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis C. V. Dis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>10-26-53</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>First seen treated 10-26-53</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4321</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>10-26-53</b> , to <b>9-26-68</b> , that (I) (we) last saw the deceased alive on <b>8-2-68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>W. F. Williams</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <b>9-27-68</b>					
22d. PHYSICIAN'S NAME (Type) <b>Dr. W. F. Williams, M.D.</b>					22e. ADDRESS <b>122 S. Centre St., Cumberland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Sept. 29, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Welsy Chapel Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Points, W. Va.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>OCT 1 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
WILLIAM			E.		MC CLEARY	SEPTEMBER 22, 1968			10:00 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
MALE		WHITE		09-17-02		66 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
WEST VIRGINIA		USA				ALLEGANY Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and cross)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND, MD.			SACRED HEART HOSP.					RAILROAD	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			ALLEGANY		CUMBERLAND			216 N. CENTRE ST.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
CHARLES					MC CLEARY	PETERS			LAURA MC CLEARY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO			705-07-9645		HOSPITAL RECORD, 900 SETON DRIVE, CUMB., MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) HYPERTROPHY OF PROSTATE, URINARY RETENTION, UREMIA									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
						9-16-55 to 9-22-68			
22a. I certify that (I) (this hospital) attended the deceased from 9-16-55 to 9-22-68, that (I) (we) lost saw the deceased alive on 9-22-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R.W. Ballin						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9-23-68	
22d. PHYSICIAN'S NAME (Type) R. W. BALLIN, M.D.						22e. ADDRESS 62 GREENE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		9/26/68		St. Patrick's Cem.		Cumberland Allegany Md.			
24. FUNERAL DIRECTOR Lewis Stein Inc. Cumb. Md.						25a. REC'D BY REGISTRAR DATE OCT 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

INVESTIGATIONS OF PROSTATE, URINARY RETENTION, URETHRA

24



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																		
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																		
12349																		
CERTIFICATE OF DEATH																		
12359																		
1. DECEASED-NAME (Type or print)			First CECIL			Middle W		Lost MC KENZIE		2a. DATE OF DEATH Month 9		Day 17		Year 68		2b. HOUR 8:45A M		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 10-11-95			6. AGE (in years lost birthday) 72 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY Md.									
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PAINTER			12b. KIND OF BUSINESS OR INDUSTRY SELF									
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CRESAPTOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER ***						
14. FATHER'S NAME First DANIEL			Middle R			Lost MCKENZIE			15. MOTHER'S MAIDEN NAME First MARY			Middle JEANNETTE			Lost HILEMAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES			16b. SOCIAL SECURITY NO. WW 1 214-05-6079			17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric thrombosis</u> 1549 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>1549</u> (b) <u>Fecal impaction</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 days</u>																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Adenocarcinoma of rectum - abdominal-perineal resection</u>																		
19a. DATE OF OPERATION <u>May 1968</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)												
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town			County			State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <u>Thomas F. Lewis M.D.</u>			22c. DATE SIGNED <u>9/18/68</u>			22d. PHYSICIAN'S NAME (Type) DR. THOMAS F. LEWIS			22e. ADDRESS CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 9/20/1968			23c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Gardens			23d. LOCATION (City or Town) Near Cumberland Alleg Md									
24. FUNERAL DIRECTOR <u>John J. Hafer, Jr.</u>			25a. REC'D BY REGISTRAR SEP 23 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>												

12345

TO THE STATE OF CALIFORNIA

IN SENATE

WHITE

(M)

AT THE STATE HOSPITAL

CHICAGO, ILL.

WILLIAM W. BENTLEY

WILLIAM W. BENTLEY

DANIEL S. JONSON

WILLIAM W. BENTLEY

DR. THOMAS H. LEWIS

SEP 1 1932

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>MARY</b>			First <b>MARY</b> Middle <b>MORGAN</b> Last <b>MORGAN</b>			2a. DATE OF DEATH <b>SEPT.</b> Month <b>25</b> Day <b>1968</b> Year		2b. HOUR <b>9:00</b> M	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>MAY 30, 1882</b>		6. AGE (In years lost birthday) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md.			
10. CITY OR TOWN OF DEATH <b>MT. SAVAGE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>MT. SAVAGE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First <b>WILLIAM</b> Middle <b>HAMMERS</b> Last <b>HAMMERS</b>			15. MOTHER'S MAIDEN NAME First <b>BRIDGET</b> Middle <b>O'BRIEN</b> Last <b>O'BRIEN</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MRS. ROBT. MULLIGAN, MT. SAVAGE, MD.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4129 Arteriosclerotic CVD.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>aging</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs?</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4221 NONE</b>									
19a. DATE OF OPERATION <input checked="" type="checkbox"/>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <input checked="" type="checkbox"/>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <input checked="" type="checkbox"/>			21f. LOCATION Street or R.F.D. No. City or Town County State <input checked="" type="checkbox"/>				
22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE</b> , 19 <b>66</b> , to <b>9/25</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>9-25</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Martin Rothstein</b>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>9-28-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>MARTIN ROTHSTEIN, M. D.</b>					22e. ADDRESS <b>48 BROADWAY, FROSTBURG, MD. 21532</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>SEPT. 28 '68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST BURIAL PARK</b>		23d. LOCATION (City or Town) (County) (State) <b>CUMBERLAND, MD.</b>			
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, FROSTBURG, MD. 21532</b>					25a. REC'D BY REGISTRAR DATE <b>SEP 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

1930

STATE OF TEXAS

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First <b>JAMES</b>		Middle <b>R.</b>		Last <b>MOWRY</b>		2a. DATE OF DEATH Month Day Year <b>SEPT. 13, 1968</b>		2b. HOUR <b>9:15PM</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>12-20-88</b>			6. AGE (In years last birthday) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>PA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>ALLEGANY</b> Md.					
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farming</b>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased admission) STATE <b>PA.</b>			13b. COUNTY <b>Bedford</b>			13c. CITY OR TOWN <b>HYNDMAN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First Middle Last <b>JACOB MOWRY</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>MIRIAH SHERMAN</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4129</b> IMMEDIATE CAUSE (a) <b>Myocardial C.V.A.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>A.S.C.V.D.</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>?</b>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4221</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/9/1968</b> , to <b>9/13/1968</b> , that (I) (we) last saw the deceased alive on <b>9/13/1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>W. Himmler</b>		DEGREE <b>DR. W. HIMMLER</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>9/17/68</b>							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>412 N. MECHANIC ST., CUMBERLAND, MD.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Sept. 17, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dry Ridge</b>		23d. LOCATION (City or Town) (County) (State) <b>Manns Choice, Bedford Co. Pa.</b>							
24. FUNERAL DIRECTOR <b>Harvey H. Zeigler, Hyndman, Pa.</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>SEP 19 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		Pa. RD			

STATE OF TEXAS

JAMES

WHITE

LEWIS & CLARK

CORRECTIONAL

INSTITUTION

IN

STATE

TEXAS

WESTERN INSTITUTION

1

DR. W. H. HARRIS

DR. W. H. HARRIS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12352		MARTLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12362	
1. DECEASED-NAME (Type or print) SARAH E. MURPHY				2a. DATE OF DEATH Month Day Year SEPTEMBER 5, 1968		2b. HOUR 1:25 P M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 3-28-1888		6. AGE (In years last birthday) 80 YRS.	
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE PENNA.		13b. COUNTY MEYERSDALE		13c. CITY OR TOWN MEYERSDALE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last LEWIS STEINLEY		15. MOTHER'S MAIDEN NAME First Middle Last HUZANNA HOUSEL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4129</u> (b) <u>ASHD, EXEM</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 hrs</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>4200 Cerebral arteriosclerosis</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>7-30, 1968</u> , to <u>9-5, 1968</u> , that (I) (we) lost saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Vanisher P. Dross</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>9-5-68</u>	
22d. PHYSICIAN'S NAME (Type) DR. V. DROSS				22e. ADDRESS 456 N. CENTRE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>9-8-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenville Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>P. D. #1 Salisbury Pa</u>	
24. FUNERAL DIRECTOR <u>H. R. Konhans Meyersdale</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 10 1968</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



100

RECEIVED

100

100

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12353

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12363

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Berman C. Norris						Month Day Year			6 a.m.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	March 16, 1895	73 YRS.	MONTHS	DAYS	HOURS	MIN.	September 15, 1968			6 a.m.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Allegany Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			Memorial Hospital			Retired Pipe Picker-Steel					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Pa.			Aliquippa			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER		
									1104 Wade St.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Isaac W. Norris			Catherine Connars								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
no						Mr. Alfred Padgett, Aliquippa, Pa.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:										SUDDEN	
IMMEDIATE CAUSE (a) CORONARY OCCLUSION											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										CORONARY SCLEROSIS	
(b) DUE TO, OR AS A CONSEQUENCE OF										---	
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4201											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.				City or Town		County State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			Benedict Skitarelic			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			BENEDICT SKITARELIC, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			September 15, 1968		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			CUMBERLAND, MARYLAND		
						ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Sept. 18, 1968		Woodlawn Cemetery		Aliquippa, Pa.					
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, Md.						SEP 17 1968		J Charles Judge			

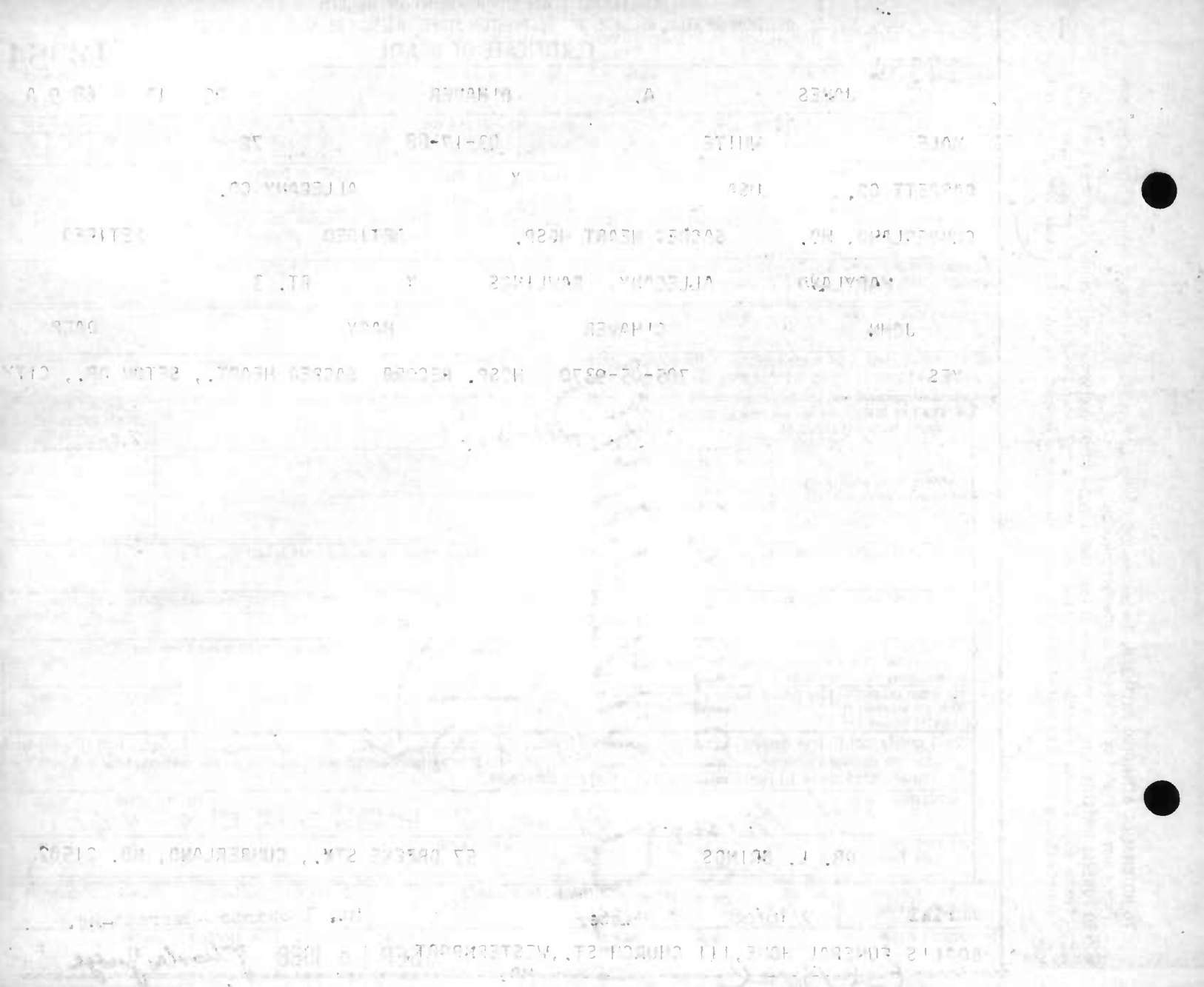
0391 1 1970

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
JAMES		A.		O'HAVER				Month 09 Day 13 Year 68		9 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		WHITE		03-17-88 92		77 7/8 YRS.		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md			
GARRETT CO.		USA				ALLEGANY CO.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital during last 24 hours of life, even if retired.)		12a. USUAL OCCUPATION (Kind of work done during last 24 hours of life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND, MD.		SACRED HEART HOSP.		RETIRED		RETIRED					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MARYLAND		ALLEGANY		RAWLINGS				RT. 3			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
JOHN				O'HAVER				MARY		DARR	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
YES unknown		705-05-9370		HOSP. RECORD		SACRED HEART, SETON DR., CITY					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>arteriosclerosis</u>										2 years	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	
21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>9-4</u> , 19 <u>68</u> , to <u>9-13</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>9-13</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>L. Brings MD</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <u>9-14-68</u>	
22d. PHYSICIAN'S NAME (Type) DR. L. BRINGS										22e. ADDRESS <u>57 GREENE ST., CUMBERLAND, MD. 21502</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE	
Burial										9/16/68	
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)	
Gaster										Rt. 1 Swanton-Garrett-Md.	
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR	
BOAL'S FUNERAL HOME, 111 CHURCH ST., WESTERNPORT, MD.										SEP 18 1968	
25b. REGISTRAR'S SIGNATURE											
										<u>J. Charles Judge</u>	

12364



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 12. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12355

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12365

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year			2b. HOUR a				
Ida Mae Platter						OF ESTI- DEATH MATED <input type="checkbox"/> 9/18/68 19 11:20							
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR a M		
F	W	7/15/1934	34 YRS					September 18, 1968			11:20 a M		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.	
Md.			USA						Allegany				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Cumberland			Memorial Hospital-DOA (?)			Housewife							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER	
Md.			Garrett			Grantsville							
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			First Middle Last			First Middle Last				
George			Mason			Anna Mae			Rizer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			212-46-2264			Calvin R. Wilt, Grantsville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO, OR AS A CONSEQUENCE OF Exanguination Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Exanguination DUE TO, OR AS A CONSEQUENCE OF Pregnancy (Placenta Praevia) Full Term (c) Full Term									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 6706													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED XX SEPTEMBER 18, 1968	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.			ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 9/21/68			23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery			23d. LOCATION (City or Town) (County) (State) Md. Star Rt. Frostburg, Allegany				
24. FUNERAL DIRECTOR <i>Ruth H. Newman</i>			ADDRESS Grantsville, Md.			25a. REC'D BY REGISTRAR SEP 20 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

12-11-77

WORLD AERIAL PHOTOGRAPHY OF BOSTON

FOR SALE  
REPRODUCTION

X

12-11-77

12-11-77

12-11-77

12-11-77

12-11-77

12-11-77

12-11-77

12-11-77

X

X

X

12-11-77

12-11-77

12-11-77

12-11-77

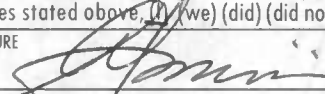
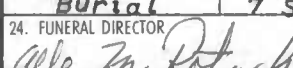
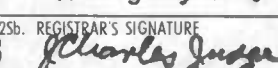


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A152A  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
12356  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>D. KATHLEEN POLAND</b>			2a. DATE OF DEATH Month Day Year <b>9 4 68</b>		2b. HOUR P M <b>12:08</b>
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>10-19-21</b>	
6. AGE (In years lost birthday) <b>46</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>W. VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>ALLEGANY</b> Md.					
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>W. VA.</b>		13b. COUNTY <b>KEYSER</b>	
13c. CITY OR TOWN <b>KEYSER</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RT. 4, BOX 105</b>	
14. FATHER'S NAME First Middle Last <b>HAROLD R. HARRISON</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>DELIA P. ROBERTS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>236 20 9025</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Ca of lung &amp; hydrothorax</b> 174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ca - Rt breast</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1 yr.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 m.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 170X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>13 Aug, 1968</b> , to <b>4 Sept, 1968</b> , that (I) (we) last saw the deceased alive on <b>4 Sept 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7 Sept 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>DR. A. J. MIRKIN</b>		22e. ADDRESS <b>CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7 Sept 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill</b>	
24. FUNERAL DIRECTOR  <b>Walter M. Rotach</b>		ADDRESS <b>Keyser, W. Va.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 16 1968</b>	
				25b. REGISTRAR'S SIGNATURE 	

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

100-100000

TO: DIRECTOR, FBI (100-100000) FROM: SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

FOR THE DIRECTOR: [Illegible]

FOR THE SAC: [Illegible]

FOR THE ASAC: [Illegible]

FOR THE CLERK: [Illegible]

FOR THE CHIEF OF POLICE: [Illegible]

FOR THE CHIEF OF FIRE: [Illegible]

FOR THE CHIEF OF HEALTH: [Illegible]

FOR THE CHIEF OF SOCIAL SERVICES: [Illegible]

FOR THE CHIEF OF EDUCATION: [Illegible]

FOR THE CHIEF OF CULTURE: [Illegible]

FOR THE CHIEF OF RECREATION: [Illegible]

FOR THE CHIEF OF TRANSPORTATION: [Illegible]

FOR THE CHIEF OF COMMUNICATIONS: [Illegible]

FOR THE CHIEF OF INFORMATION: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12357

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

12367

1. DECEASED-NAME (Type or print) <b>LILLIAN</b>			First Middle Last <b>PRESSMAN</b>			2a. DATE OF DEATH <b>SEPT.</b> Month <b>28</b> Day <b>1968</b> Year			2b. HOUR M		
3. SEX <b>FEMALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>MAY 8, 1891</b>			6. AGE (In years last birthday) <b>77</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>ALLEGANY</b> Md.		
10. CITY OR TOWN OF DEATH <b>FROSTBURG</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>18 N. GRANT STREET</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <b>RETIRED CLERK</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>DEPT. STORE</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>ALLEGANY</b>			13c. CITY OR TOWN <b>FROSTBURG</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>18 N. GRANT STREET</b>			14. FATHER'S NAME First Middle Last <b>HENRY PRESSMAN</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>MARGARET FARRELL</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO. <b>212-01-7469</b>			17. INFORMANT <b>ROBT. PRESSMAN, FROSTBURG, MD. 21532</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute CVA</b> <b>4379</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>331X</b> (b) <b>Cerebral arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Indeterminate</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Chronic ASHD</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>January 1, 1968</b> , to <b>Sept. 28, 1968</b> , that (I) (we) last saw the deceased alive on <b>Sept. 23, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>G. Paige Strong</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>9/30/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>A. PAIGE STRONG, M. D.</b>						22e. ADDRESS <b>167 E. MAIN ST., FROSTBURG, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <b>OCT. 2, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>ST. MICHAELS CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG, MD.</b>		
24. FUNERAL DIRECTOR <b>JOSEPH. R. DURST, FROSTBURG, MD. 21532</b>						25a. REC'D BY REGISTRAR DATE <b>OCT 3 1968</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

RECEIVED

NOV 18 1954

U.S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C.

White Oak

Central Experimental Station

White Oak

X

NOV 18 1954

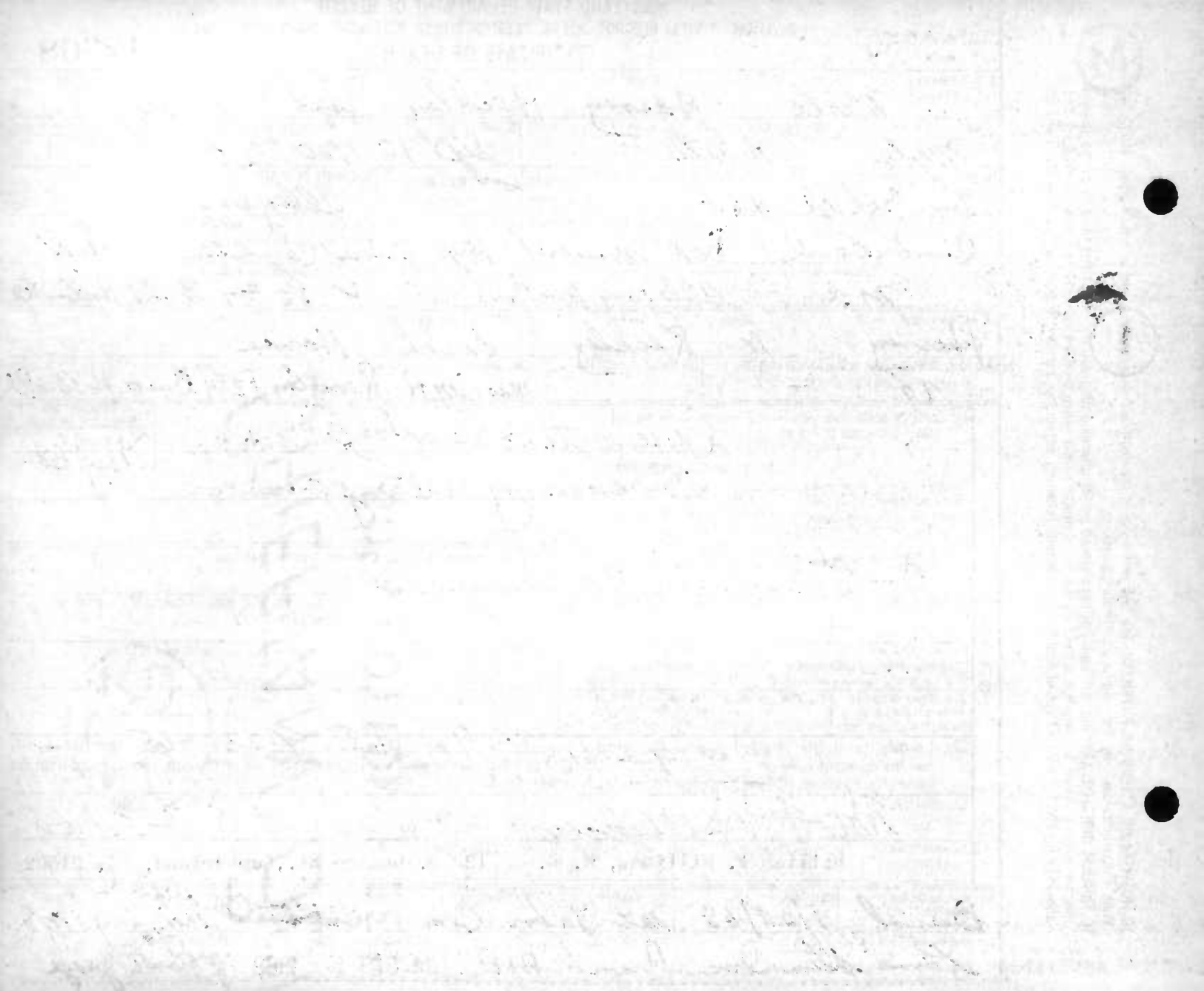
11/30/54

White Oak

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12358		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12368	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last Merle Harvey Reckley			2a. DATE OF DEATH Sept 23, 1968			2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Sept 10, 1900		6. AGE (In years last birthday) 68 YRS.	
7a. BIRTHPLACE (State or foreign country) Town Creek Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Alleyany Md.	
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOR Memorial Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Self.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Alleyany		13c. CITY OR TOWN Town Creek		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Pt #4 Bruce Hollow Rd		14. FATHER'S NAME First Middle Last Harvey W. Reckley		15. MOTHER'S MAIDEN NAME First Middle Last Sarah House			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 4109		17. INFORMANT Address Mrs. M.H. Reckley Pt #4 Bruce Hollow Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) 4201 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Since Aug 68.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Bronchogenic Carcinoma							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4-9-1968 to 9-23-1968, that (I) (we) last saw the deceased alive on 9-9-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W. F. Williams		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9-24-68	
22d. PHYSICIAN'S NAME (Type) William F. Williams, M. D.		22e. ADDRESS 122 S. Centre St., Cumberland, Md.		21502			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/25/68		23c. NAME OF CEMETERY OR CREMATORY Mt Taber Cem.		23d. LOCATION (City or Town) (County) (State) Cumberland Md.	
24. FUNERAL DIRECTOR Louis Stein Inc.		ADDRESS Cumb. Md.		25a. REC'D BY REGISTRAR DATE OCT 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed, within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director's office, page 3 should be detached for use as the burial-transit permit. Then please remove (can papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12359		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12369	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First ROLAND		Middle B.		Last REDMOND	
2. DATE OF DEATH		Month SEPTEMBER		Day 2		Year 1968	
3. SEX MALE		4. RACE COLORED		5. DATE OF BIRTH MAY 11, 1898		6. AGE (In years last birthday) 70 YRS.	
7a. BIRTHPLACE (State or foreign country) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.	
10. CITY OR TOWN OF DEATH CUMBERLAND, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Baggage Porter		12b. KIND OF BUSINESS OR INDUSTRY B & O R R	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 426 PINE AVENUE.		14. FATHER'S NAME SAUL		15. MOTHER'S MAIDEN NAME NETTIE		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	
16b. SOCIAL SECURITY NO. 705-05-4482		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		17. ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> 4409 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 450.0 Diabetes Mellitus, Carcinoma Prostate							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 8-18, 1968, to 9-2-68, 1968, that (I) (we) last saw the deceased alive on 9-2-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William P. James		22c. DATE SIGNED 9/5/68		22d. PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES		22e. ADDRESS 441 N. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/5/1968		23c. NAME OF CEMETERY OR CREMATORY Sumner Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Alleg Md	
24. FUNERAL DIRECTOR Charles E. Hafer		25a. REC'D BY REGISTRAR SEP 9 1968		25b. REGISTRAR'S SIGNATURE Charles E. Hafer			





1  
FOR STATE HEALTH DEPT. **M**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00  
01  
1  
2

12360 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12370

1. DECEASED-NAME (Type or Print) <b>Rose Ella Ross</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>9</b> Day <b>21</b> Year <b>1968</b> 3:00 P			2b. HOUR <b>P</b>			
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Feb. 17, 1885</b>	6. AGE (In years last birthday) <b>83</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b>	IF UNDER 24 HRS. MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>Sept.</b> Day <b>21</b> Year <b>1968</b> 3:00 P	2d. HOUR <b>P</b>
7a. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b>			
10. CITY OR TOWN OF DEATH <b>Westernport</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Kolbergs Hill</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>H.W.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Westernport</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Kolbergs Hill</b>
14. FATHER'S NAME First <b>George H.</b> Middle <b>Dunk</b>			15. MOTHER'S MAIDEN NAME First <b>Annie</b> Middle <b>E.</b> Last <b>Schramm</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>220-34-1501A</b>		17. INFORMANT ADDRESS <b>Pearl Kazlo Westernport, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Osteal Occlusion, right</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>September 21, 1968</b>			
ADDRESS (Street, city, town, or county) <b>CUMBERLAND, MARYLAND</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/24/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Philos</b>		23d. LOCATION (City or Town) (County) (State) <b>Westernport, Alle. Md.</b>			
24. FUNERAL DIRECTOR <b>Boal</b>				ADDRESS <b>Westernport, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 25 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

12/20

1000 2000

1000 2000

1000 2000

1000 2000

1000 2000

1000 2000

1000 2000

1000 2000

1000 2000

1000 2000

1000 2000

1000 2000

1000 2000

1000 2000

1000 2000

1000 2000

1000 2000

1000 2000

1000 2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First GEORGE		Middle W		Last RUMMER		2a. DATE OF DEATH SEPT. Month Day 24 Year 1968		2b. HOUR AM 2:00	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 1-22-08 1909		6. AGE (In years lost birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) CUMB. MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.					
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Room Helper		12b. KIND OF BUSINESS OR INDUSTRY B & O R. R.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER ROUTE 1, VALLEY ROAD			
14. FATHER'S NAME First Middle Last GEORGE RUMMER		15. MOTHER'S MAIDEN NAME First Middle Last CLARA TWIGG									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <input checked="" type="checkbox"/> No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>492X Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis &amp; plaque &amp; general atheroma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>5271</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>January 1967</u> to <u>Sept 26, 1968</u> , that (I) (we) last saw the deceased alive on <u>Sept 23, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Blane M. Schindler</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>9/27/68</u>							
22d. PHYSICIAN'S NAME (Type) DR. BLANE M. SCHINDLER		22e. ADDRESS 43 GREENE ST., CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept. 26, 1968		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.					
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR SEP 27 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

100-1

REPORT OF DEATH

100-1

ON 10-10-1960

100-1

100-1

100-1

100-1

100-1

100-1

100-1

100-1

100-1

100-1

100-1

100-1

100-1

100-1

100-1

100-1

100-1

100-1

100-1

100-1

100-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12362		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		12372	
Item #5, Film G404		9/19/68 km		CERTIFICATE OF DEATH	
1. DECEASED-NAME (Type or print)			First	Middle	Lost
ALBERT L. SCHADE			2a. DATE OF DEATH Month Day Year SEPTEMBER 10, 1968		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 9-27-97	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		6. AGE (In years lost birthday) 70 YRS.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Owner of Radiator Service	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 510 MARSHALL ST.			
14. FATHER'S NAME First Middle Lost NICHOLAS SCHADE		15. MOTHER'S MAIDEN NAME First Middle Lost ELIZABETH DIABOLD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 212-32-8349		17. INFORMANT Address MEMORIAL HOSPITAL, CUMB. MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Short time</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4201</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>9-5-1968</u> to <u>9-10-1968</u> , that (I) (we) last saw the deceased alive on <u>9-10-1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Wm. F. Williams</u>		22c. DATE SIGNED <u>9-11-68</u>		22d. PHYSICIAN'S NAME (Type) DR. W. F. WMS.	
22e. ADDRESS CUMBERLAND, MD.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE 9-13-68		23c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Maryland	
24. FUNERAL DIRECTOR H. Lee Silcox		ADDRESS 404 Decatur St., Cumb., Md.		25a. REC'D BY REGISTRAR DATE SEP 16 1968	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

100-33-321

RECEIVED SEP 19 1944

100-33-321

ALLIANCE

MEMORIAL HOSPITAL, GENE, MD.

ALLIANCE HOSPITAL, GENE, MD.

ALLIANCE HOSPITAL, GENE, MD.

100-33-321

100-33-321

100-33-321

100-33-321



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>STELLA P SHAFFER</b>						2a. DATE OF DEATH Month <b>9</b> Day <b>10</b> Year <b>68</b>			2b. HOUR P <b>12:35 M</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>2-4-84</b>			6. AGE (In years lost birthday) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>PENNA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md.					
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>PA.</b>			13b. COUNTY <b>Bedford</b>		13c. CITY OR TOWN <b>HYNDMAN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First Middle Last <b>BENJAMIN BRADIGAN</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>SARAH EVANS</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) <b>No</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <b>216-22-6321</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tobacco pneumonia</b> <b>492 X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary emphysema, advanced</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Malnutrition</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>10 yrs</b> <b>6 months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>5271</b> <b>Cirrhosis of liver</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>8-31</b> , 19 <b>68</b> , to <b>9-10</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>9-10</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>V. P. Dross MD</b> DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <b>DR. V. DROSS</b>						22e. ADDRESS <b>CUMBERLAND, MD.</b>					
23a. BURIAL, CREMATION, or other disposition		23b. DATE <b>Sept. 13, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hyndman Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Hyndman, Bedford Co., Pa.</b>			
24. FUNERAL DIRECTOR <b>Harvey H. Feigler</b>						ADDRESS <b>Hyndman, Pa.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

STATEMENT OF WORK

CHAPTER

STELLA

REMARKS

WHITE

2-1-11

ALL BIRTH

U.S.A.

REMARKS IN 2-1-11

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS IN 2-1-11

REMARKS

DR. V. 1022

10/1/11

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

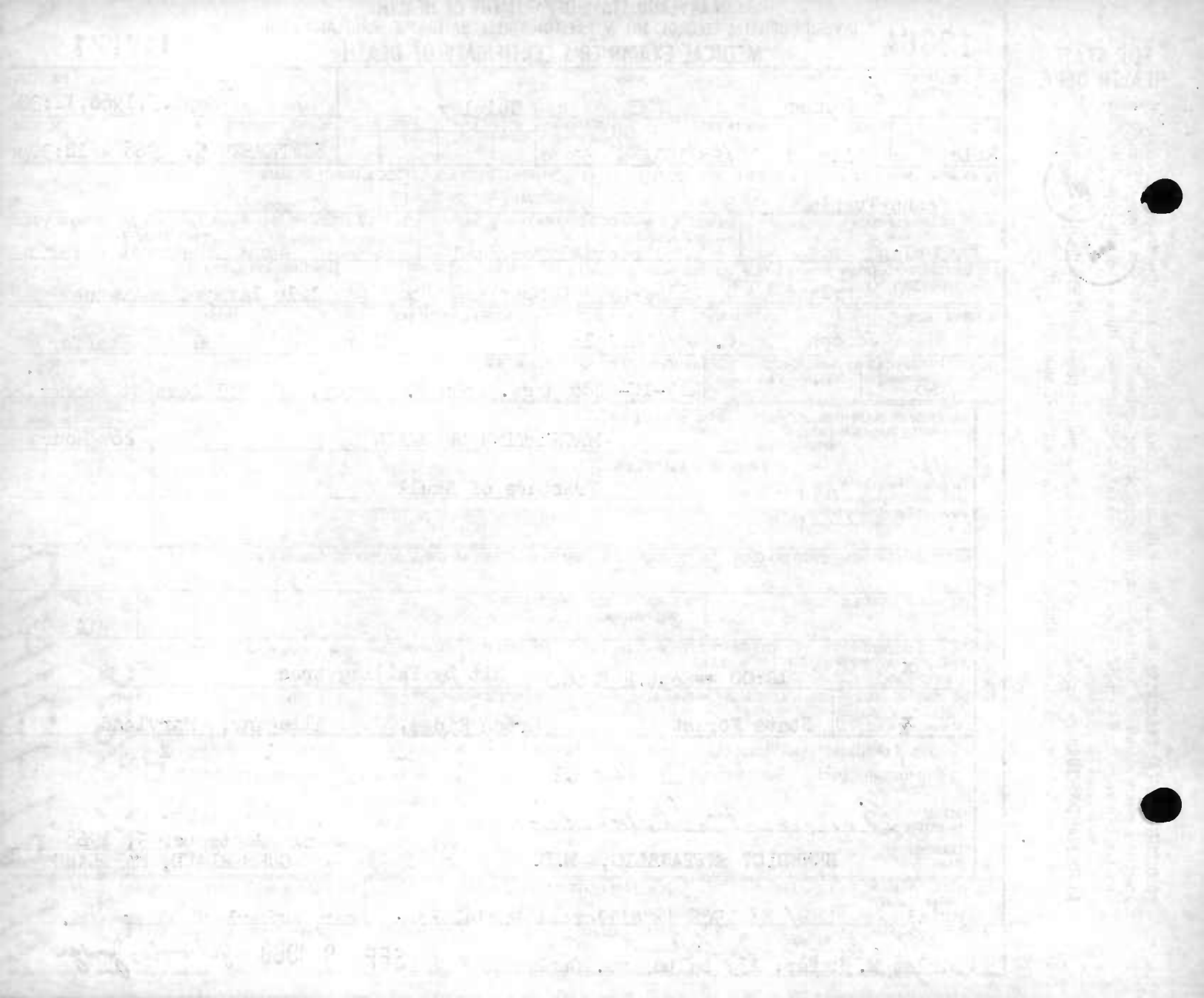
12364

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12374

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year			2b. HOUR <input checked="" type="checkbox"/> 12:30 PM		
Banner			NMI			Shipley					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	12/28/1914	53 YRS.	MONTHS	DAYS	HOURS	MIN.	SEPT. 5, 1968			12:30 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Pennsylvania		U S A		Allegany Md.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			Memorial Hospital			Forman			Dept of Forest & Parks		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER	
Maryland				Allegany		Cumberland				1216 Lafayette Avenue	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			First Middle Last					
Joseph O. Shipley			Clara NMI Shaffer								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			217-10-4385			Mrs. John J. Harvey.			503 Williams St Cumberland Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>MACERATION OF BRAIN</u>										26 Hours	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <u>Fracture of Skull</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
910.8											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			10:00 AM Sept. 4 19 68			Hit by falling tree					
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town County State		
			State Forest			Green Ridge,			Allegany, Maryland		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			BENEDICT SKITARELIC, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			September 5, 1968		
						ADDRESS (Street, city, town, or county)			CUMBERLAND, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial		9/ 8/ 1968		Hillcrest Burial Park				Near Cumberland Alleg Md.			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Charles E. Hafer				230 Balto Ave. Cumberland Md				SEP 9 1968		Charles Judge	

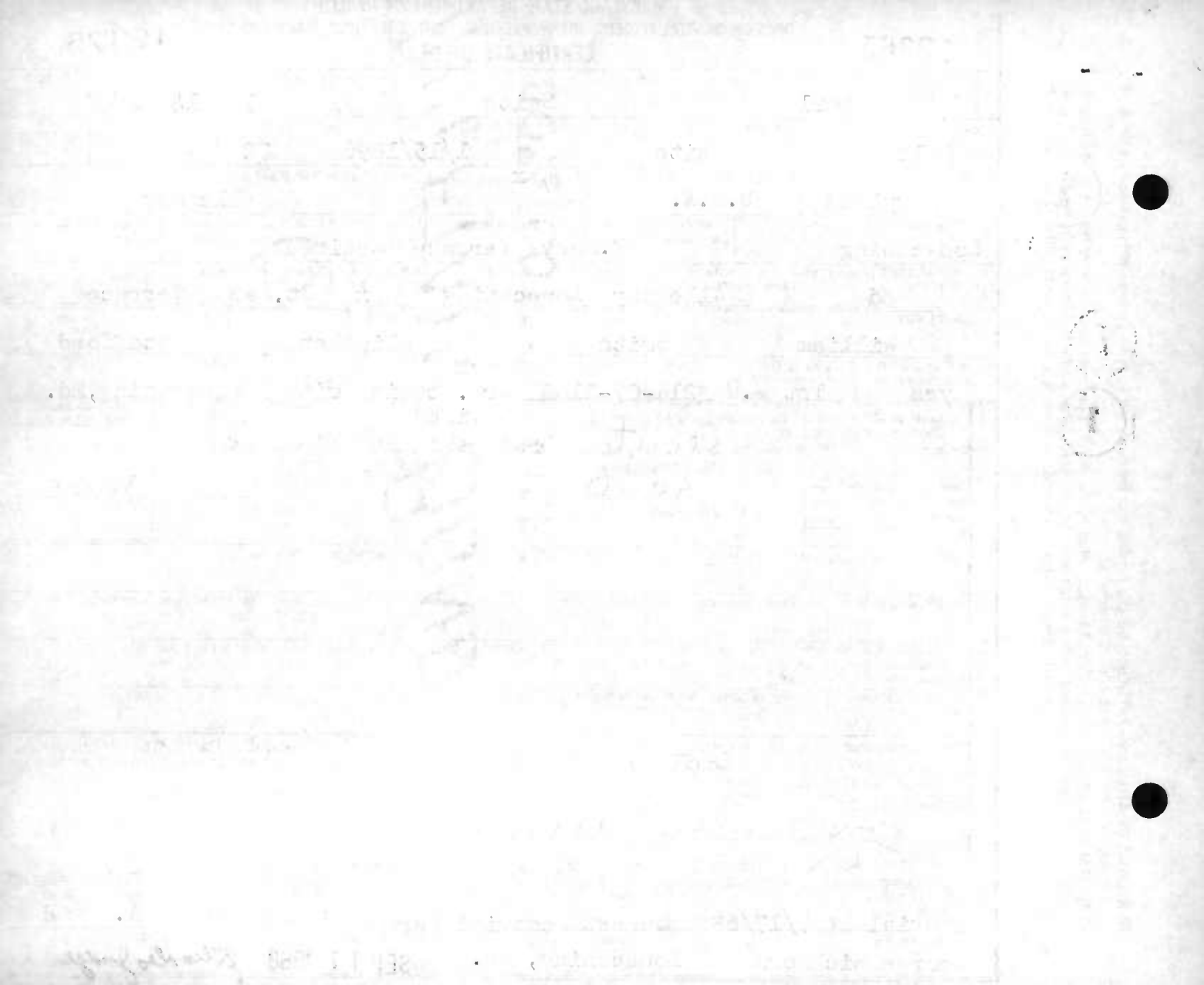


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 4-10-71  
30M REV. 4-78

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>Earl Smith</b>						2a. DATE OF DEATH Month <b>9</b> Day <b>14</b> Year <b>1968</b>		2b. HOUR <b>M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>1/15/1896</b>		6. AGE (in years last birthday) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b>		Md.			
10. CITY OR TOWN OF DEATH <b>Lonaconing</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. Marys Terrace</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Lonaconing</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>St. Marys Terrace</b>		
14. FATHER'S NAME First Middle Last <b>William Smith</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Elizabeth Stafford</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>yes</b> (If yes give war or dates of service) <b>1st W.W</b>			16b. SOCIAL SECURITY NO. <b>214-07-2140</b>		17. INFORMANT <b>Mrs. Jessie Smith</b>			Address <b>Lonaconing, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <b>4201</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>1960</b> , to <b>Sept. 14 1968</b> , that (I) (we) last saw the deceased alive on <b>Sept 10 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>L.R. Miles, Jr. M.D.</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>9-16-68</b>					
22d. PHYSICIAN'S NAME (Type) <b>L.R. MILES, JR., M.D.</b>		22e. ADDRESS <b>LONA CONING MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/17/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Cumberland A. Md</b>				
24. FUNERAL DIRECTOR <b>George Eichhorn</b>				Lonaconing, Md.		25a. REC'D BY REGISTRAR DATE <b>SEP 17 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/78

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last <b>Lenora Ellen Smith</b>						2a. DATE OF DEATH Month Day Year <b>Sept 20 1968</b>			2b. HOUR <b>4.45 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Feb. 22, 1901</b>			6. AGE (In years lost birthday) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b> Md.						
10. CITY OR TOWN OF DEATH <b>Luke</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>107 Pratt</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Hom.</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Luke</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>107 Pratt</b>			
14. FATHER'S NAME First Middle Last <b>Charles T. Beckman</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary A. Steiding</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>		(If yes: give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>William H. Smith, Sr. Luke, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <b>10 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201 Chronic Bronchitis</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>1958</u> , to <u>Sept 20, 1968</u> , that (I) (we) last saw the deceased alive on <u>9-20-68</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>William W. Lesh MD.</b>				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>9/21/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>William W. Lesh</b>				22e. ADDRESS <b>Westernport, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/23/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fitzwater</b>			23d. LOCATION (City or Town) (County) (State) <b>Swanton Md.</b>					
24. FUNERAL DIRECTOR ADDRESS <b>E. S. Boal Westernport, Md.</b>				25a. REC'D BY REGISTRAR <b>SEP 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						

MEDICAL CERTIFICATION



1992-1993

• • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12367 CERTIFICATE OF DEATH 12377											
1. DECEASED-NAME (Type or print) First Middle Last <b>Thomas E. Smith</b>					2a. DATE OF DEATH Month Day Year <b>Sept, 13th. 1968</b>		2b. HOUR <b>M</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>10/9/1966</b>		6. AGE (In years lost birthday) <b>1</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> CHILD <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b> Md.					
10. CITY OR TOWN OF DEATH <b>Lonaconing</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and house no.) <b>Jackson ST.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>None</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>			13b. CITY OR TOWN <b>Allegany</b>			13c. CITY OR TOWN <b>Lonaconing</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Jackson St.</b>	
14. FATHER'S NAME First Middle Last <b>John E. Smith</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>Dohna Shockey</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name (unknown) (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>John E. Smith Lonaconing, Md. (Father)</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4299 Myocardial Ischemia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4344</b> (b) <b>Cardiomegaly</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Hydrocephalus, complete blockage</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>1966</b> , to <b>Sept. 13, 1968</b> , that (I) (we) last saw the deceased alive on <b>Sept. 13, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>L.R. Miles, Jr.</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>9-14-68</b>							
22d. PHYSICIAN'S NAME (Type) <b>L.R. MILES, JR., M.D.</b>				22e. ADDRESS <b>LONACONING, MD. 21539</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/15/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Lonaconing, Md.</b>					
24. FUNERAL DIRECTOR <b>George Eichhorn</b>				ADDRESS <b>Lonaconing, Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



Handwritten text at the bottom left, possibly a signature or date.

# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

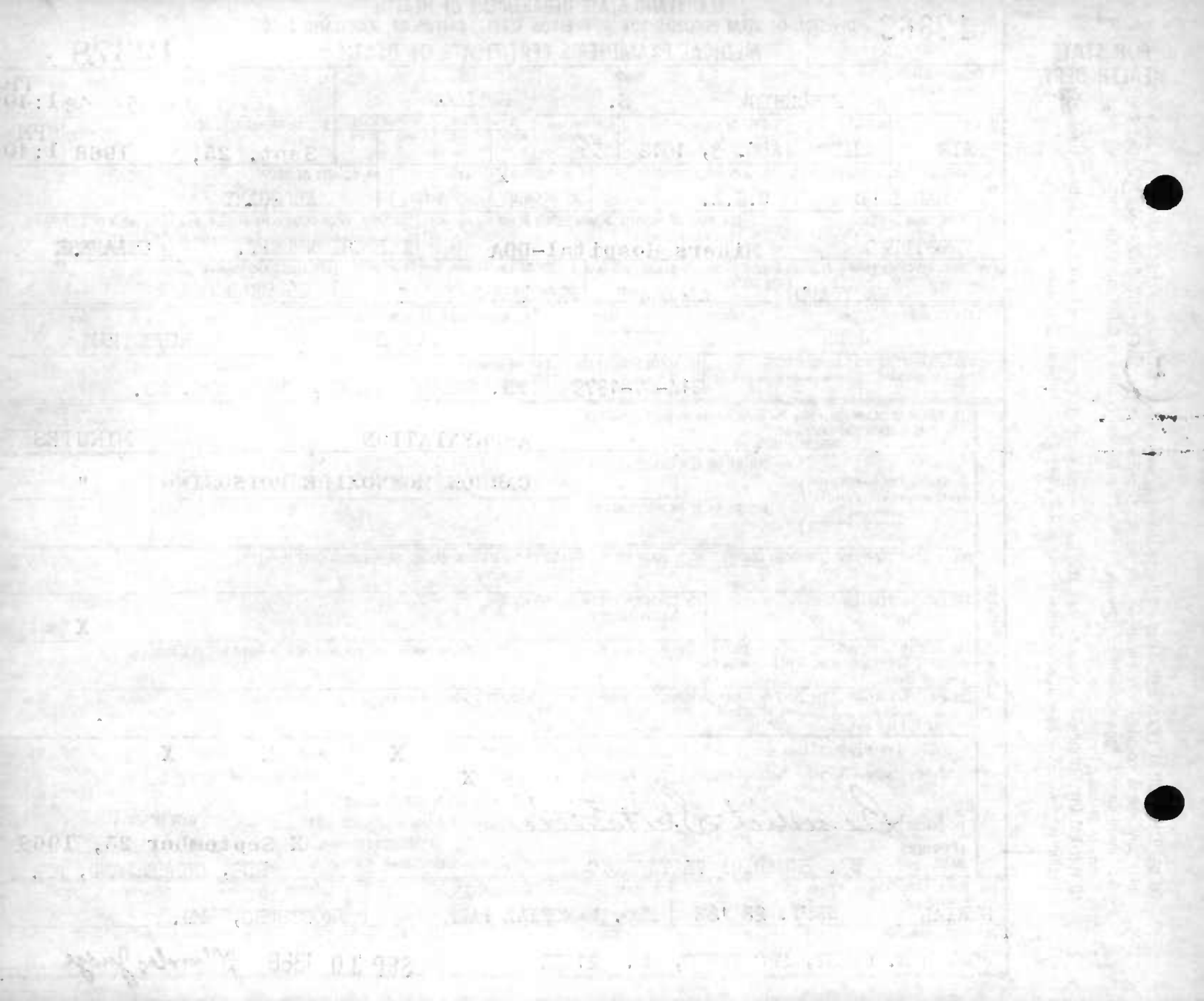
12368

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12378

1. DECEASED-NAME (Type or Print)		First <b>FREDERICK</b>		Middle <b>S.</b>		Last <b>SNELSON</b>		2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> 9 - 25 - 1968		2b. HPM 1:40 PM	
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>AUG. 3, 1912</b>		6. AGE (In years last birthday) <b>56</b> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____		2c. DATE PRONOUNCED DEAD Month <b>Sept.</b> Day <b>25</b> Year <b>1968</b>	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b>				Md.	
10. CITY OR TOWN OF DEATH <b>FROSTBURG</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Miners Hospital-DOA</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>EXTRUSION DEPT.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CELANESE</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>FROSTBURG</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>26 BRADDOCK</b>			
14. FATHER'S NAME First <b>JOHN</b>		Middle <b>SNELSON</b>		Last <b>ANNIE</b>		15. MOTHER'S MAIDEN NAME First <b>ANNIE</b>		Middle <b>ROWBOTHAM</b>		Last <b>ROWBOTHAM</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>214-07-1379</b>		17. INFORMANT <b>MRS. SARAH SNELSON, FROSTBURG, MD.</b>		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>9521 ASPHYXIATION</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>CARBON MONNOXIDE POISONING</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>9731</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____		City or Town _____		County _____		State _____	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		EXAMINER'S NAME (Type) <b>DR. BENEDICT SKITARELIC</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>September 25, 1968</b>	
				ADDRESS (Street, city, town, or county) <b>RD9, CUMBERLAND, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>SEPT. 28 '68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FBG. MEMORIAL PARK</b>		23d. LOCATION (City or Town) <b>FROSTBURG, MD.</b>		(County)		(State)	
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, FROSTBURG, MD. 21532</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>SEP 30 1968</b>		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div>12369</div> <div>CERTIFICATE OF DEATH</div> <div>12379</div>											
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR		
First		Middle		Last		Month			Day		
CLARENCE		C		STEPHEN		SEPT.			17 1968		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)			7. IF UNDER 1 YEAR	
MALE		WHITE		10-15-1888			79 YRS.			MONTHS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY	
GRANTSVILLE, MD.		USA					ALLEGANY			Own Farm	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)						
CUMBERLAND		MEMORIAL HOSPITAL			Retired Farmer						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MD.				ALLEGANY		ACCIDENT		YES		ROUTE 1	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
First		Middle		Last		First		Middle		Last	
PETER				STEPHEN		ISABELLE				BROADWATER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT					
No				220-03-7052		MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Carcinoma of prostate</u>											?
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>Carcinoma prostate gland</u>											- yrs -
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
177X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
		HOUR A.M. Month Day Year									
		P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/15/1968</u> , to <u>9/17/1968</u> , that (I) (we) last saw the deceased alive on <u>9/15/1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
<u>W. Himmler</u>										22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
DR. WALTER N. HIMMLER						412 N. MECHANIC ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		9/20/68		Glade Cemetery		Accident		Garrett, Md.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
<u>Walter K. Newman</u>		SEP 19 1968		<u>Charles Judge</u>							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please read carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
12370										
12380										
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
First Middle Last					Month Day Year			M		
Harry B. Ternent					Sept 12 1968					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. YRS.		
Male		White		Oct, 30th 1889		78				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
MD.		USA				Allegany				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Frostburg		Miners Hospital		Retired Merchant						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MD.		Allegany Lonaconing						1 Castle Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
George Ternent			Jeanette Darnley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT				
Yes W-W-#1						Sampson Ternent, Lonaconing, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Ischemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Atherosclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u> <u>years</u> <u>years</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>4201</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 12 1968</u> , 19 <u>65</u> to <u>Sept. 12, 1968</u> , that (I) (we) last saw the deceased alive on <u>Sept 12 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.										
22b. SIGNATURE <u>L.R. Miles</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>9-13-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>L.R. MILES, JR. M.D.</u>					22e. ADDRESS <u>LONA CONING MD 21539</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		9/15/1968		Oak Hill Cemetery		Lonaconing, Md.				
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
George Eichhorn					Lonaconing, Md.		SEP 16 1968		Charles Judge	

1878

THE UNIVERSITY OF CHICAGO  
LIBRARY

1878

1878

1878

THE UNIVERSITY OF CHICAGO  
LIBRARY

1878

1878

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

THE UNIVERSITY OF CHICAGO  
LIBRARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <b>RALPH SYLVESTER UPLINGER</b>						2a. DATE OF DEATH Month Day Year <b>SEPTEMBER 7, 1968</b>			2b. HOUR A M <b>2:50</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>DECEMBER 18, 1909</b>		6. AGE (In years last birthday) <b>58</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md.					
10. CITY OR TOWN OF DEATH <b>CUMBERLAND, MD.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Roofer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self Empo.</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>506 SPRINGDALE ST.</b>			
14. FATHER'S NAME First Middle Last <b>CURTIS UPLINGER</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>JOSEPHINE SHEWBRIDGE</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1621</b> IMMEDIATE CAUSE (a) <b>Carcinoma, Left Lung &amp; Metastases</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>1638</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital), attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <b>Sept. 5</b> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Calvin Y. Hadidian</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>9-9-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>DR. CALVIN Y. HADIDIAN</b>						22e. ADDRESS <b>203 GREENE STREET, CUMBERLAND, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Sept. 10, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Porter Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hyndman, Pa.</b>					
24. FUNERAL DIRECTOR ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>SEP 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

100-374

UNITED STATES DEPARTMENT OF JUSTICE

ALBANY, NEW YORK, MAY 1, 1934

TO THE ATTORNEY GENERAL, WASHINGTON, D. C.

FROM THE DISTRICT ATTORNEY, ALBANY, NEW YORK

SUBJECT: ALBANY, NEW YORK, MAY 1, 1934

RE: ALBANY, NEW YORK, MAY 1, 1934

ALBANY, NEW YORK, MAY 1, 1934

ALBANY, NEW YORK, MAY 1, 1934

ALBANY, NEW YORK, MAY 1, 1934

ALBANY, NEW YORK, MAY 1, 1934

ALBANY, NEW YORK, MAY 1, 1934

ALBANY, NEW YORK, MAY 1, 1934

ALBANY, NEW YORK, MAY 1, 1934

ALBANY, NEW YORK, MAY 1, 1934

ALBANY, NEW YORK, MAY 1, 1934

ALBANY, NEW YORK, MAY 1, 1934

ALBANY, NEW YORK, MAY 1, 1934

ALBANY, NEW YORK, MAY 1, 1934

ALBANY, NEW YORK, MAY 1, 1934

ALBANY, NEW YORK, MAY 1, 1934

ALBANY, NEW YORK, MAY 1, 1934

ALBANY, NEW YORK, MAY 1, 1934

ALBANY, NEW YORK, MAY 1, 1934

ALBANY, NEW YORK, MAY 1, 1934

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12372		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12381		
CERTIFICATE OF DEATH								
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		
JOHN O. WALKER						SEPTEMBER 20, 1968		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		
MALE		WHITE		3-12-15		55 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
MARYLAND		U.S.A.				ALLEGANY		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done last Monday)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND		MEMORIAL HOSPITAL		Retired Tech.		A.B.L. LAB.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
MARYLAND		ALLEGANY		FROSTBURG		90 W. COLLEGE AVE.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME		
WILLIAM B. WALKER						EMILY T. TAYLOR		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT			
			214-07-5421		MEMORIAL HOSPITAL, CUMB. MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal congestive heart failure</u>						6 weeks		
3969 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>410x</u>								
(b) <u>Chronic valvular heart disease, with aortic stenosis</u>								
DUE TO, OR AS A CONSEQUENCE OF								
(c) <u>mitral insufficiency, rheumatic</u>						10 years?		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
<u>Aortic and Mitral Valve Replacement, 1 1/2 years ago</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		yes.	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town		
				Street or R.F.D. No.		County		
				State				
22a. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , <u>1966</u> , to <u>20 Sept</u> , <u>1968</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>20 Sept</u> , <u>1968</u> , and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) (did) ( <u>did not</u> ) view the body after death.								
22b. SIGNATURE <u>W. A. Vanormer, M.D.</u>				22c. DATE SIGNED <u>21 Sept 68</u>				
22d. PHYSICIAN'S NAME (Type) <u>DR. W. A. VANORMER</u>				22e. ADDRESS <u>122 S. CENTRE ST., CUMB. MD.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		9-23-68		F.B.G. MEMORIAL PARK,		FROSTBURG, ALLEGANY. MD.		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
JOSEPH R. DURST, FROSTBURG, MD.				DATE SEP 25 1968		<u>Charles Judge</u>		

12345

RECEIVED

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12373 CERTIFICATE OF DEATH 12382									
1. DECEASED-NAME (Type or print) <b>Minnie</b>			First Middle Last <b>Wamsley</b>			2a. DATE OF DEATH at <b>10:05 AM</b>		2b. HOUR <b>A.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>4/19/1870</b>		6. AGE (In years last birthday) <b>98</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany County.</b>			
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Allegany County Infirmary</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>101 Mary Street</b>	
14. FATHER'S NAME First Middle Last <b>Marshall Mullins</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Elizabeth Golden</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>220-52-9938</b>		17. INFORMANT <b>P.O. Box 599, Cumberland, Md. Allegany County Infirmary records.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute coronary thrombosis</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF <b>a few minutes</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chr. A. S.H.D. with hypertension</b> DUE TO, OR AS A CONSEQUENCE OF <b>many years</b> (c) <b>arteriosclerosis</b> <b>many years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>4201</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Sep 6</b> , 19 <b>68</b> , to <b>Sep 20</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Sep 20</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John A. Topper</b> DEGREE <b>MD</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>Sep 20, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>John A. Topper</b>				22e. ADDRESS <b>Memorial Hospital, Cumberland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>SEPT. 23, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ZION MEMORIAL PARK</b>		23d. LOCATION (City or Town) (County) (State) <b>CUMBERLAND MD.</b>			
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>				ADDRESS <b>CUMBERLAND, MD.</b>		25a. REC'D BY REGISTRAR <b>SEP 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	





Female

White

1/15/1937

36

West Virginia

U. S. A.

Allegheny County

Chapman

Allegheny County

Homewood

Id.

Allegheny County

101 Main Street

Marshall

White

Allegheny

Golden

101 Main Street, Allegheny County, West Virginia, U. S. A.

Memorial Hospital, Cumberland, Md.

SEP 11 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12374												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												12383																																							
1. DECEASED-NAME (Type or print)												First GILBERT												Middle H.												Last WARNICK												2a. DATE OF DEATH Month Day Year SEPTEMBER 8, 1968												2b. HOUR 3:35 PM			
3. SEX MALE				4. RACE WHITE				5. DATE OF BIRTH 9-24-1910				6. AGE (In years lost birthday) 57 YRS.				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS. HOURS MIN.																																											
7a. BIRTHPLACE (State or foreign country) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH ALLEGANY Md.																																																			
10. CITY OR TOWN OF DEATH CUMBERLAND				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Electrician				12b. KIND OF BUSINESS OR INDUSTRY Paper Mill																																																			
13a. USUAL RESIDENCE (Where deceased admission) STATE MD.				13b. CITY OR TOWN ALLEGANY				13c. CITY OR TOWN RAWLINGS				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER RT.#3, BOX 68																																															
14. FATHER'S NAME First Middle Last CALVIN J. WARNICK				15. MOTHER'S MAIDEN NAME First Middle Last ROSA PAUGH																																																											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 217-07-6563				17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.																																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Right Lung - Metastasis</u> 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 163X																																																															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																																																							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>9-8</u> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																															
22b. SIGNATURE <u>Calvin J. Whitworth, M.D.</u>												DEGREE ATTENDING <input type="checkbox"/> MED. <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS. DIRECTOR PHYS.				22c. DATE SIGNED 9-9-68																																															
22d. PHYSICIAN'S NAME (Type) DR. F. B. WHITWORTH												22e. ADDRESS 305 WASHINGTON ST., CUMBERLAND, MD.																																																			
23a. BURIAL, CREMATION, BURNING (Specify) Burial				23b. DATE 9/12/68				23c. NAME OF CEMETERY OR CREMATORY Bernard.				23d. LOCATION (City or Town) (County) (State) Swanton Garrett Md.																																																			
24. FUNERAL DIRECTOR <u>W. L. Bral</u>												Westernport, Md.				25a. REC'D BY REGISTRAR DATE SEP 16 1968				25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>																																											

(14)

(1)

STATE OF DEATH  
WARRICK  
ALBERT  
WHITE  
2-24-1910  
ALLIANCE  
USA  
GENERAL AND MEMORIAL HOSPITAL  
T. ALLEMAN, BELLING  
CALVIN J. WARRICK  
USA  
GENERAL AND MEMORIAL HOSPITAL, BELLING  
SEP 1 1908  
SEP 1 1908  
SEP 1 1908

DR. F. S. HILL  
SEP 1 1908  
SEP 1 1908  
SEP 1 1908

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12375

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12384

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR	
JANE		M.		WIANT				<input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year 9/16/ 68		8 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years lost birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	White	Nov. 12. 1886	81 YRS	MONTHS DAYS		HOURS MIN.		Month Day Year Sept 16 1968		8P M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		USA		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		ALLEGANY				Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
CUMBERLAND		DOA MEMORIAL HOSPITAL		HOUSEWIFE		OWN HOME					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
MARYLAND		ALLEGANY		CUMBERLAND		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		ROUTE 3, VALLEY ROAD			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
First Middle Last		First Middle Last									
JOHN WILKINSON		JOSEPHINE MARTIN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		UNKNOWN		JAMES A. WIANT		FAIRLESS HILLS, PA.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
4109		IMMEDIATE CAUSE (a)		CORONARY OCCLUSION		SUDDEN					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF		ARTERIOSCLEROSIS		---					
		(b)									
		DUE TO, OR AS A CONSEQUENCE OF									
		(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. P.M.									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		Benedict Skitarelic		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		BENEDICT SKITARELIC, M.D.		RT. 9, CUMBERLAND, MD.		22b. DATE SIGNED		9/16/68			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
BURIAL		SEPT. 19, 1968		HILLCREST BURIAL PARK		CUMBERLAND, MD.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
BYRON KIGHT		CUMBERLAND, MD.		DATE		SEP 20 1968					



RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <b>Walter Lundy Wigfield</b>						2a. DATE OF DEATH Sept. Month Day Year <b>Sept. 19 1968</b>			2b. HOUR M <b>1238</b>		
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>1882 Oct. 2. 1887</b>		6. AGE (In years last birthday) <b>86 1/2 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Flintstone</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b> Md.					
10. CITY OR TOWN OF DEATH <b>Cumberland</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Kinch Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Paper hanger</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>hanging paper</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>606 Maryland Ave.</b>		
14. FATHER'S NAME First Middle Last <b>Johnaton Wigfield</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Deborah S Shryhoff</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address <b>Mrs. Minnie Smith Cumberland, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>428 X</b> <b>Myocarditis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>10 yrs</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b> <b>1 yr</b> <b>10 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4221</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 20, 1968</b> to <b>Sept 19, 1968</b> , that (I) (we) lost the deceased alive on <b>Sept. 16, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Clayton J. Smith</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <b>9/20/68</b>						
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/23/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Charles Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Md</b>				
24. FUNERAL DIRECTOR <b>Louis Stein, Inc. Cumberland, Md</b>					25a. REC'D BY REGISTRAR <b>Oct 1 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>				





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12376										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										12385									
1. DECEASED-NAME (Type or print) First Middle Last <b>Joseph Wiland</b>										2a. DATE OF DEATH Month Day Year <b>9/7/1968</b>										2b. HOUR M <b>1</b>									
3. SEX <b>Male</b>					4. RACE <b>White</b>					5. DATE OF BIRTH <b>2/2/1892</b>					6. AGE (In years last birthday) <b>76</b> YRS.					IF UNDER 1 YEAR MONTHS DAYS <b>76</b>					IF UNDER 24 HRS. HOURS MIN. <b>76</b>				
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>					7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>					B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <b>Allegany</b> Md.														
10. CITY OR TOWN OF DEATH <b>Frostburg</b>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Miners Hospital</b>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Carpenter</b>					12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>					13b. COUNTY <b>Allegany</b>					13c. CITY OR TOWN <b>Lonaconing</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER <b>Robin Street</b>									
14. FATHER'S NAME First Middle Last <b>Cyrus Wiland</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>Elizabeth Gray</b>																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b>					16b. SOCIAL SECURITY NO. <b>13b. COUNTY</b>					17. INFORMANT <b>John Willand, Lonaconing, Md.</b>										Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Ischemia</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>421.0</b> (b) <b>Coronary Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Atherosclerosis</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Peripheral vascular insufficiency</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 1968</b> , to <b>Sept 7, 1968</b> , that (I) (we) lost saw the deceased alive on <b>Sept 7, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <b>L.R. Miles, Jr.</b>										22c. DATE SIGNED <b>9-9-68</b>										22d. PHYSICIAN'S NAME (Type) <b>L.R. MILES, JR</b>									
22e. ADDRESS <b>LONA CONING MD</b>																													
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE <b>9/10/1968</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>					23d. LOCATION (City or Town) (County) (State) <b>Lonaconing, Md.</b>														
24. FUNERAL DIRECTOR <b>George Eichhorn, Lonaconing, Md.</b>										25a. REC'D BY REGISTRAR DATE <b>SEP 10 1968</b>										25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									

100-100000

RECEIVED

100-100000



100-100000

RECEIVED

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000



100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year			2b. HOUR	
DORIS ANN WRIGHT						OF ESTI- DEATH MATED <input type="checkbox"/> SEPT. 3, 1968			1:a m	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR	
FEMALE	WHITE	4 22 36	32 YRS.					SEPT. 3, 1968	1:a m	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
FROSTBURG, MD.			USA					ALLEGANY Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND			SACRED HEART HOSPITAL			HOUSEWIFE				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MD.			ALLEGANY		FROSTBURG				BOX 106 EDKHART MINES	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
CHARLES F. KERR			MARTHA PHILLIPS KERR							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		
NO			220-32-4911		SACRED HEART HOSPITAL			900 SETON DRIVE CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis of Lungs, bilateral DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary emboli DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24-48 Hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 465X Encephalomalacia (Respirator Brain)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED SEPTEMBER 3, 1968				
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.			ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL			9-5-1968		FROSTBURG MEMORIAL		FROSTBURG, ALEG. MD			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Joseph R. Duvost, Frostburg, Md.						DATE SEP 6 1968		Charles Judge		

100-100000

DR 137

WHITE A 02 02

ALLEGANY

PARTITION, W.

300000 HEART HOSPITAL

CONTRACTED

NOV 195

ALLEGANY COUNTY

NO.

MADISON TRILLER KIDS

CHARGE 2

NO SECTION

300000 HEART HOSPITAL

NO